Second Quarter 2021

MedStar Health

MedStar Select Provider Newsletter

Use the Provider Web Portal to comply with CMS.

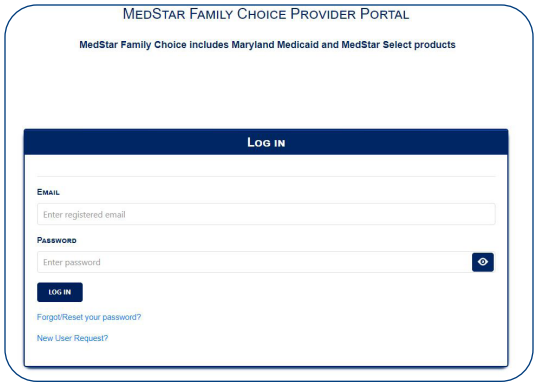
To comply with CMS regulations regarding the accuracy of our provider directory information, MedStar Family Choice has developed the MedStar Family Choice Provider Web Portal. Please note this portal services providers who participate in MedStar Select and MedStar Family Choice.

The MedStar Family Choice Provider Web Portal serves as a quality control mechanism allowing providers to view their information in our system. Your provider information is communicated to the MedStar Select members and provider community via our Find a Provider website. Other systems within MedStar Family Choice also use this information to process authorizations, claims and issue reimbursement checks. Provider Web Portal Services include:

- New User Registration
- Password Reset
- Provider and Group Changes
- Review Summary of Changes
- Quarterly Data Validations
- Provider Web Portal User Guide

Visit the MedStar Family Choice Provider Web Portal at **ProviderPortal.MedStarFamilyChoice.com** to register.

Before registering, you will need to have access to the following information:



- Group DBA (doing business as) Name
- Group Tax ID
- Group Type II NPI (Group NPI)

To complete the registration process:

- Click on New User Request
- Enter your group administrator ID (email) currently on file with MedStar Family Choice
- You will receive an email to complete the registration.
- Once you complete the initial registration process on the portal, you will receive an email link to complete the registration process. This link is only available for 24 hours or you will have to start the registration process again

For problems with registration, send a detailed email to mfc-providerrelations2@medstar.net.

Verify your office information online.

Please check **MedStarProviderNetwork.org** to confirm your office information is displaying correctly on the searchable online directory. If there have been any changes or you become aware of an error, please use the Provider Web Portal or contact Provider Relations to resolve. Help us to ensure that MedStar Select has the most accurate and up to date information!

Welcome new providers to MedStar Select!

MedStar Health would like to welcome the following new providers to our network!

- **Henry Chiropractic and Wellness Center** (Chiropractic Medicine, Lexington Park, St. Mary's County)
- **Key Vitality Solutions LLC** (Family Medicine, Balitmore County)
- **Optimum Family Clinic LLC** (Family Medicine, Baltimore City)
- **Privia Medical Group Henry B Fox MD** (Medical Oncology, Bethesda, Montgomery County)
- **Waypoint Integrative Health LLC** (Acupuncture, Balitmore County)

In addition, we welcome the following ancillary provider groups into the network:

- Dialysiss: **Dialyze Direct MD, LLC**

Outpatient rehabilitation services are covered.

Outpatient rehabilitation services, including medically necessary physical therapy, occupational therapy and speech therapy, are covered benefits for MedStar Select plans. These services are provided in various outpatient settings, such as hospital outpatient departments and Comprehensive Outpatient Rehabilitation Facilities (CORFs). Refer to the Summary of Benefits posted at **MedStarProviderNetwork.org** to determine the applicable copay or coinsurance, which does vary based on plan, as well as any coverage restrictions. A listing of all participating providers is also available at this website.

Medically necessary chiropractic services are also covered under MedStar Select; however, coverage restrictions do apply. In addition to the Summary of Benefits, please refer to the policies posted on **MedStarProviderNetwork.org** (PA.059 and MP.111), which provide coverage and billing guidelines. Prior authorization is required for members under the age of 13. MedStar Select offers a 30-visit limit on these services.

About the Notice of Privacy Practices.

All new members receive a copy of our Notice of Privacy Practices (Notice) upon joining MedStar Select. The Notice outlines how MedStar may use and disclose our members' information, as well as how members could access this information. Policies and procedures are also in place to protect our members' written and electronic protected health information. Therefore, to ensure the privacy and security of its members' personal health information, MedStar Select requires its providers to abide by a number of medical record documentation standards. These standards include provisions such as:

- Providing a compliant notice of privacy practices to members
- Complying with all federal, state, and local laws and regulations pertaining to medical records and releases
- Securing both paper and electronic medical records and releases
- Ensuring the confidentiality of member information through the creation of standards
- Releasing information to authorized individuals, including individuals from government agencies such as MDH, DOH, and/or HHS for quality assurance and auditing purposes
- Reporting to MedStar in a timeframe required by law or other applicable requirement

Providers must promptly report breaches related to MedStar Select members in accordance with the provider agreement and any other applicable laws, regulations, and requirements. Methods to report breaches include calling the MedStar Health Privacy Office at **410-772-6606**, through the Integrity Hotline at **877-811-3411** (toll free) or emailing us at privacyofficer@medstar.net.

A copy of the Notice is available on MedStar's website at **MedStarHealth.org/MHS/Patients-and-Visitors/Privacy-Policy**.

Hard copies can be provided upon request by calling at **855-242-4872**

Remember to screen for hypertension.

Hypertension is a recognized global disease and affects patients of every demographic. Therefore, we encourage all practices, regardless of specialty, to check each patient's blood pressure during an office visit with their provider, even if the patient has no prior history of high blood pressure.

Many factors may increase a patient's blood pressure and it is recommended that members with a high blood pressure reading be asked if they are under treatment for hypertension. If they are not, the patient should be encouraged to schedule an appointment with his or her primary care provider to screen for potential disease.

Providers performing blood pressure checks on each patient at every office visit ensures that diseases, like hypertension, do not pass undetected and improves the chances for successful treatment. Together, the medical community can reduce the growing effects of hypertension on the patient population.

For questions or concerns regarding this communication, please contact Provider Relations at mfc-providerrelations2@medstar.net or **800-905-1722, option 5** (MD).

How to refer members to specialists.

Coordination of a member's care requires that providers communicate with specialists, therapists and other specialty providers. Even though written referrals are not required for MedStar Select members, referring providers should give the member's name, reason for the referral, relevant medical information and the referring provider's name, as well as their national provider identifier (NPI), to the referred facility, specialist or behavioral health provider. This information is needed on the CMS-1500 form.

The referring provider can communicate this information to the other provider by calling, faxing through a prescription, or using a Universal Referral form. The referring provider should be communicating this information directly to the specialist without involving the member. Once the member has seen the specialist, the specialist must communicate findings and treatment plans to the referring provider within 30 days from the date of the visit. Both providers should jointly determine how care is to proceed.

If a member has self-directed care to a specialist, the specialist should contact the PCP, if applicable, to obtain medical records to determine what care has been completed in order to avoid duplicating services already performed. If the member does not have a PCP, obtain a medical history from the member to try to determine whether any prior services have been performed.

Providers should refer members within network. If there is a need for an out-of-network specialist, Medical Management must authorize the care. The PCP or specialist should call Medical Management at **855-242-4875** to obtain an authorization for services to be rendered by a non-participating provider. Failure to obtain an authorization could result in claims denials, or claims processing at a lower benefit level for MedStar Select.

Request membership and insurance cards.

Each MedStar Select member receives an identification card, which can be used only by the person listed on the card.

Use of a member's card by another person is insurance fraud and is grounds for the member's termination from the health plan. Possession of a member ID card does not guarantee eligibility.

Providers must request any and all insurance cards from the member before performing services. Providers should verify eligibility by going online at **MedStarProviderNetwork.org** or by calling Provider Services at **855-222-1042**.

Urgency for medical record requests for appeals.

Members have the right to file appeals regarding claim payment or organizational determinations. In some situations MedStar Select need to request medical records in order to process the appeal.

Your timely response to this request is needed in order for us to best serve our members and meet regulatory requirements. If you receive a request for medical records from the plan, please respond as expeditiously as possible.

Contact us.

We are here to help. Please reference the below list of numbers if you have any questions or concerns.

Member Services
855-242-4872 PHONE
Monday through Friday, 7 a.m. to 7 p.m.

Care Management
888-959-4033 PHONE
Monday through Friday, 8:30 a.m. to 5 p.m.

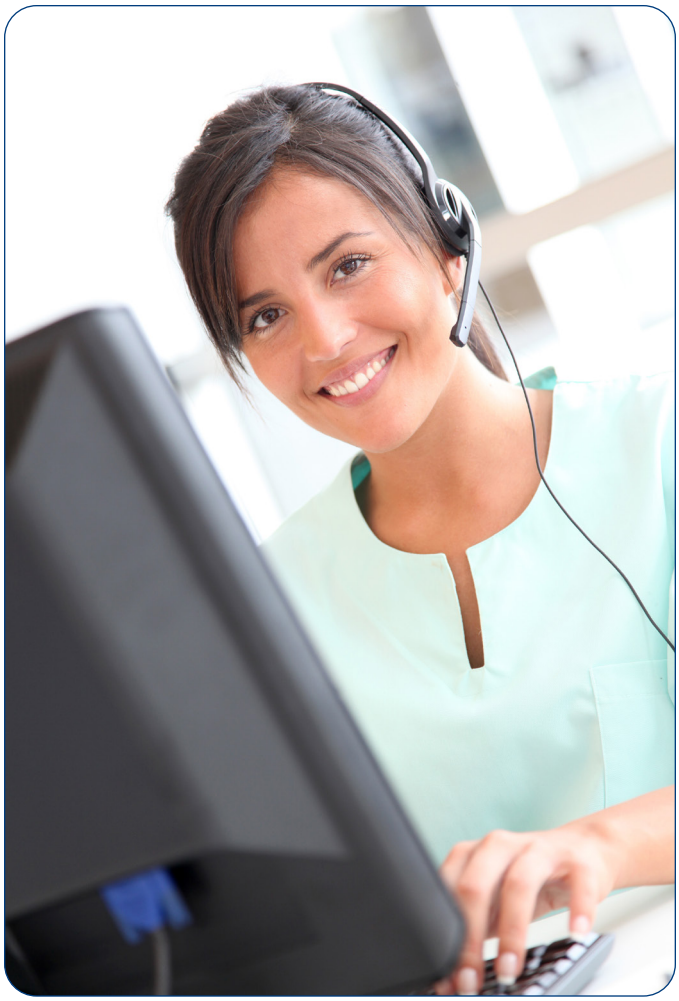
Medical Management/Prior Authorization
855-242-4875 PHONE
Monday through Friday, 8:30 a.m. to 5 p.m.

Provider Services
(For claims and eligibility inquiries)
855-222-1042 PHONE
Monday through Friday, 8:30 a.m. to 5 p.m.

Provider Relations
(For credentialing/re-credentialing or practice additions/terminations/address changes)
800-905-1722, option 5 PHONE
Monday through Friday, 8:30 a.m. to 5 p.m.

Interactive Voice Recognition
855-275-1251 PHONE

To verify member eligibility, access the provider website at **MedStarProviderNetwork.org** \or call Provider Services at **855-222-1042**.



How to find a provider in our online directory.

Finding a participating MedStar Select provider couldn't be easier! Visit **MedStarProviderNetwork.org** to look up participating PCPs and specialists by logging on to visiting our online provider directory.

Providers can be found by completing one or more of the search fields to get updated information instantly. If your office does not have access to the web, please contact Provider Relations at **800-905-1722, option 5**.

An overview of Complex Care.

Complex Care is an essential component of MedStar Health's Care Advising services, which are used to support the practitioner-patient relationship and plan of care. This program evaluates clinical, humanistic and economic outcomes on an ongoing basis, and uses evidence-based practice guidelines to emphasize the prevention of exacerbations and complications. Complex Care targets patients with at least one of five chronic conditions: congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD), diabetes, and asthma.

Complex Care uses coordinated health care interventions and communications for populations with significant self-care needs. Evidence-based medicine and a team approach are used to:

- Empower patients
- Support behavior modification
- Reduce incidence of complications
- Improve physical functioning
- Improve emotional well-being
- Support the physician/patient relationship
- Emphasize and reinforce use of clinical practice guidelines

The team approach to care is supported by a multi-disciplinary roster of health professionals, including a registered nurse Care Advisor or health coach, pharmacist, dietitian, and social worker. They work together, informing and collaborating with the patient's primary care physician to enhance Care Advising.

Program Goals

The goal of Complex Care Care is to effectively impact the health outcome and quality of life of patients with chronic conditions. This is accomplished by using a multi-faceted approach based on assessment of patient needs, ongoing care monitoring, evaluation, and tailored patient and practitioner interventions. Complex Care can also reduce hospital length of stay and lower overall costs.

Patient Identification

MedStar Health systematically evaluates patient data against a set of identification and stratification criteria. For Complex Care, criteria are established to identify eligible patients, stratify them by risk, and determine the appropriate intervention level. The following data sources are used to identify patients, when available:

- Enrollment data
- Medical claims or encounters
- Pharmacy claims

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- Assessment screening results
- Practitioner referrals
- Data collected through utilization (UM) and care management (CM) activities
- Data collected from health management or wellness programs
- Laboratory results
- Electronic medical/health records

Once identified, patients are stratified to determine the appropriate intervention level based on their known needs and status. Stratification is a dynamic process that can change as a patient's condition changes.

Patient Engagement and Support

Patients identified for Complex Care are considered to be participating unless they specifically request to receive no program services or to "opt-out." Once identified as eligible, patient engagement follows the steps outlined below:

Welcome Packet Mailed	A staff member of MedStar Health's care team sends patient a welcome packet. The welcome packet includes information about education and support provided through Care Advising, the extended care team, required legal and regulatory information, and how Care Advising services support the patient-provider relationship.
Introductory Phone Call	The welcome packet is followed by a phone call from a Care Advising staff member. Over the phone, the staff member shares the advantages of Care Advising and encourages the patient to participate.
Physician Notification	When a patient engages in Care Advising, a staff member notifies the patient's primary care physician directly.

Practitioner Feedback

On an as needed, individual basis, the care advisor or health coach will alert the practitioner to time-sensitive care opportunities, such as an asthma patient increasing his or her use of a rescue inhaler or a heart failure patient reporting weight gain.

If you know of a patient who you believe may benefit from participation in Complex Care, or to request a hard copy of our disease management materials please call us at **855-959-4033**, Monday to Friday, 9 a.m. to 5 p.m. EST.

We welcome your referrals, questions, and feedback.

Helping patients live well with chronic disease self-management programs at MedStar Health.

Living Well is a seven-week program that can help your patients take charge of their health and their life.

This program is designed for adults living with a chronic condition, such as heart disease, diabetes, cancer, depression, chronic pain, lung disease or any chronic health concern.

The program covers:

- Problem solving
- Managing emotions
- Exercise
- Managing medications
- Cognitive symptom management
- Communication skills
- Goal setting
- Developing patient/physician partnerships
- Advanced directives
- Health eating and much more

Community Health at MedStar Health is providing these workshops at **no cost** to participants. Classes are highly interactive.

The program was developed by Stanford University. It has been tested and evaluated with the following results.

- Showed significant improvements in exercise, cognitive symptom management and communication with physicians
- Spent fewer days in the hospital
- Had fewer outpatient visits and hospitalizations

Referring a Patient is Easy

Complete a referral order in MedConnect by clicking on the "Orders" tab and selecting "Community Health Program Referral." Once the referral is sent, a member from our team will follow up with your patient for program intake and enrollment.

Patients can visit **MedStarHealth.org/LivingWell** for specific dates and locations. Hospital calendars are updated regularly.

For more information about Living Well, contact your local hospital's Community Health department, email communityhealth@medstar.net or call **877-367-5864**.

Understand MedStar Select false claims and statements requirements.

This is intended to provide you with information on laws pertaining to the prevention and detection of fraud, waste and abuse, in accordance with the requirements of the Federal Deficit Reduction Act of 2005.

Federal False Claims Act

The Federal False Claims Act, 31 U.S.C. §§ 3729-3733, applies to persons or entities that knowingly and willfully submit, cause to be submitted or conspire to submit a false or fraudulent claim, or that use a false record or statement in support of a claim for payment to a federally funded program. The phrase "knowingly and willfully" means that the person or entity had actual knowledge of the falsity of the claim, or acted with deliberate ignorance or reckless disregard for the truth or falsity of the claim. Persons or entities that violate the Federal False Claims Act are subject to civil monetary penalties (42 U.S.C. § 1320a-7a) and payment of damages due to the federal government. Under the False Claims Act, those who knowingly submit, or cause another person or entity to submit, false claims for payment of government funds are liable for three times the government's damages plus civil penalties. In 2020, the penalties were updated to $11,665 to $23,331 per false claim. The Federal False Claims Act provides that any person with actual knowledge of false claims or statements submitted to the federal government may bring a False Claims Act action in the government's name against the person or entity that submitted the false claim. This is known as the False Claims Act's "qui tam," or whistleblower provision. Depending on the outcome of the case, a whistleblower may be entitled to a portion of the judgment or settlement. The Federal False Claims Act provides protection to whistleblowers that are retaliated against by an employer for investigating, filing or participating in a False Claims Act lawsuit.

State False Claims Acts

A number of states have enacted false claims acts in an attempt to prevent the filing of fraudulent claims to state-funded programs. The District of Columbia has established such an act under Title 2, Chapter 3 of the District of Columbia Code. The District of Columbia law provides that any person who knowingly presents or causes to be presented a false claim, record or statement for payment by the District, or conspires to defraud the District by getting a false claim paid, can be liable to the District for penalties and damages. District of Columbia law allows whistleblowers to bring claims under certain circumstances and protects whistleblowers from retaliation by employers. Virginia has a similar law, known as the Taxpayers Against Fraud Act, established under Chapter 3 of Title 8.01 of the Virginia Code. Virginia's law also permits whistleblowers to bring actions in the name of the Commonwealth of Virginia and protects whistleblowers from discrimination by employers. Maryland has a similar law, called the Maryland False Health Claims Act of 2010, originally enacted as Maryland Senate Bill 279. The Maryland law prohibits actions constituting false claims against state health plans or programs, permits whistleblowers to bring actions under the law and provides protection for whistleblowers from retaliation. In Maryland, the civil penalty can be up to $10,000 for each violation. There can be an additional penalty of up to three times the amount of the damages that the state sustains. Depending on the outcome, the whistleblower may be entitled to a portion of the judgment or settlement.

Close the gap by scheduling diabetic eye exams!

While May was Healthy Vision Month, there is still time to ensure your patients with diabetes get scheduled for a retinal eye exam. Diabetic members are at an increased risk for experiencing a variety of eye problems including retinopathy, cataracts and glaucoma. Diabetic retinopathy is the most common diabetic eye disease and the leading cause of blindness in American adults. The diabetic eye exam is one of the most challenging clinical measures across MedStar. Working together with your patients, you can help improve measure performance and get your patients the care they need. To meet this measure, patients must receive an exam either from an ophthalmologist or optometrist. Your help is appreciated in improving performance on this important clinical measure!

HEDIS Definition

Patients 18-75 years old in current year with diabetes (type 1 or type 2) who had a retinal eye exam by an eye care professional (optometrist or ophthalmologist) in current year or an eye exam with negative results for retinopathy in prior year.

Documentation Requirements
(MMG providers: also refer to MedConnect Guidance)

- Evidence of annual retinal or dilated eye exam by optometrist or ophthalmologist;
  - ➢ copy of eye exam report in EMR; or
  - ➢ patient reported retinal or dilated eye exam with approximate date, provider type and results (positive or negative for diabetic retinopathy)
- Exception to an annual exam is if there was negative retinal or dilated exam for retinopathy in the prior year.

Common Barriers

Comprehensive diabetes care requires multiple providers in executing a plan of care. A lack of symptoms may deter some members with diabetes from getting their eyes screened for damage, and they may not fully understand their risks for diabetic retinopathy. As their physician, you are able to influence your patients and emphasize the importance of getting this exam.

Helpful Hints/Member 2021 Benefits Available

- Diabetes Eye Exam is **$0 cost** to the member through Group Vision Services (EyeMed) only. If the patient obtains their Diabetes Eye Exam during a specialist visit (e.g., ophthalmologist), there is a $30 co-pay.
- For assistance in getting an appointment your patients can contact Member Services: **855-242-4872 (TTY 711)**; Vision provider services are also available: **866-265-4626**.

Learn about MedStar Select pharmacy benefits.

MedStar Select members are covered under a prescription benefit plan administered by Evolent and CVS/Caremark. As a way to help manage healthcare costs, authorize generic substitution whenever possible. Consider prescribing a brand name on the preferred drug list at **MedStarProviderNetwork.org** if you believe a brand name product is necessary.

Please note:

- Generics should be considered the first line of prescribing.
- The drug list represents a summary of prescription coverage; it is not inclusive and does not guarantee coverage.
- The member's prescription benefit plan may have different copay for specific products on the list.
- Unless specifically indicated, drug list products will include all dosage forms.
- Log in to Caremark.com to check coverage and copay information for a specific medicine.
- For drugs covered under the medical benefit that require prior authorization, please refer to **855-266-0712**. An example would be drugs administered in the office would be covered under the medical benefit. Patients are not picking up the prescription at the pharmacy. Please reference the prior authorization list on **MedStarProviderNetwork.org**.

Where can MedStar Select Members get their Vaccines?

Any in-network pharmacy can administer and bill for BOTH the cost of the drug and the administration of the drug through the member's pharmacy benefit. Some vaccines can also be administered in the provider office. Please visit **MedStarProviderNetwork.org** for a listing of covered vaccines and where they can be administered. The following seasonal and nonseasonal vaccines are available to MedStar Select members at no additional cost at any participating in-network pharmacy.

Seasonal Vaccines:

- Injectable Flu vaccine (Trivalent and Quadrivalent)
- Injectable High-Dose vaccine
- Intranasal Flu vaccine

Nonseasonal Vaccines:

- Pneumonia
- Diptheria
- Zoster (Zostavax®)
- Tetanus
- Diptheria Toxoids
- Pertussis
- Hepatitis A
- Hepatitis B
- Haemophilus B
- Human Papillomavirus (Gardasil®)
- Meningiococcal
- Varicella
- Inactivated Poliovirus
- Measles
- Mumps
- Rubella
- Rotavirus
- Meningococcal
- Varicella

Use Provider OnLine for claims, benefit, and eligibility information.

Provider OnLine is specifically designed for practitioners and providers affiliated with MedStar Select. The portal allows quick and efficient access to claims, benefit, and eligibility information for members, our associates and covered dependents. In addition, providers can chat online with Provider Services by clicking the link at the bottom of the home page.

In order to check eligibility and benefits, simply enter the member's identification number, last name, and first name, then click "Search." Eligibility results for applicable dependents and subscribers display within seconds. The result details show the member's specific benefits and effective date of benefits.

The Claim Inquiry search allows providers to search by member, associate, covered dependent or claim information online to obtain real time claims status. Detailed CMS-1500 and UB claim detail is supplied, including adjustment reasons, by clicking on the applicable claim from the search results.

Providers who have questions on claims can compose an email to Provider Services on the claim detail screen directly.You can also save time by messaging or chatting directly with Provider Services through the Provider OnLine portal. Communications are sent directly to the appropriate service area by selecting the applicable topic.

Provider OnLine also offers the capability to accept prior authorizations submitted by providers electronically. Once submitted, providers are able to view the status of their request as well as make edits up until a decision has been rendered.

If you are not already registered for Provider OnLine, sign up through **Bit.ly/ProviderOnLine**. For further information on the Provider OnLine portal, please contact Provider Services at **855-242-1042**.

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The MedStar Select Provider Newsletter is a publication of MedStar Health. Submit new items for the next issue to MedStar Family Choice Provider Relations at **mfc-providerrelations2@medstar.net**.

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It's how we treat people.