Second Quarter 2016

MedStar Health

MedStar Select/Medicare Choice Provider Newsletter

SNP Model of Care

The MedStar Medicare Choice D-SNP/C-SNP are special needs plans serving patients eligible for Medicare and Medicaid and patients diagnosed with diabetes or congestive heart failure (CHF), respectively.

What Does this Mean?

These plans were approved by CMS under the documentation of an evidence-based Model of Care. The Model of Care is designed to address the unique healthcare needs of those eligible for Medicare and Medicaid. Importantly, there is also a focus on the socio-economic and behavioral health factors that may impact a patient's ability to manage illness and access quality care. The Model of Care aims to improve the patient's:

- Access to medical, social and mental health services
- Coordination of care across the continuum through a dedicated RN care advisor
- Transitions of care across healthcare settings and providers
- Access to preventative health services
- Health outcomes

How Does this Impact You, as the Valued Provider?

The Model of Care is a best practice because it offers the following benefits:

- High level of attention to each patient's specific health and individual needs
- Health assessments to identify risks and concerns
- Individualized attention and coordination of care from assigned RN care advisors
- Individualized care plan for all patients enrolled
- Coordination of transitions of care across healthcare settings and providers
- Network providers experienced with SNP members

As a provider caring for SNP members, CMS requires that you are educated on essential information about special needs plans and special needs members. For your convenience, we offer various methods to complete this training. A signed attestation of completion is required in order to track completion for CMS reporting.

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In order to support your members, an online course has been added to **MedStarProviderNetwork.org**.

You will be eligible to receive 1.75 CME credits after answering all questions and completing all information on the Attestation of Course Completion for CME Credits Eligibility form. Once the attestation form is completed and signed, please fax it to **703-890-1636**.

Upon completion of this course, you will be able to:

- Define SNP and the eligible member's demographics.
- Describe the Model of Care for our SNP programs and how it improves the member's health and healthcare experience.
- Understand the key elements of the Model of Care's "whole person" management approach, including the individualized care plan and interdisciplinary care team.
- Identify the measurable performance outcomes.

MedStar Medicare Choice's mission is to serve vulnerable populations with a holistic, integrated model to ensure they receive timely access to quality care in a setting most appropriate for their needs.

What's Next?

To complete the online SNP Model of Care training, please visit **MedStarProvider Network.org** and click on SNP Provider Training – Earn 1.75 CMEs. Review the materials, complete and sign the attestation form and fax it to **703-890-1636**.

For questions about completing the SNP training and other methods available, please contact your provider relations representative.

Risk Adjustment Factor (RAF)

Each April, we re-introduce our Risk Assessment initiative and explain how RAF will impact your practices.

RAF is designed to help accurately assess the health status of your patient population, especially those with more complex conditions. RAF allows for a comprehensive account of your patient's clinical profile, including conditions treated by specialists, complications and comorbidities.

The goal of the RAF program is to ensure that each and every condition affecting your patients is documented appropriately in the medical record and billed on a claim. This helps to appropriately direct resources from the health plan to your practices. It also will help prepare you for the changes CMS will be implementing over the next few years to move toward value-based reimbursement.

Improving our RAF processes will increase reimbursements from CMS, allowing MedStar Medicare Choice to reflect the true severity of illness in our patient population and to invest more into our clinical programs and other population health resources.

To learn more about RAF, go to **MedStarProviderNetwork.org**, where you can access a RAF training video.

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Our Ask for You

MedStar Medicare Choice encourages participating providers to conduct an annual comprehensive exam and patient assessment for each of our Members in exchange for an enhanced level of reimbursement which recognizes the level of time and effort that you and your practice are investing. To support your efforts, MedStar Medicare Choice will provide you with patient data indicating specific patients on your panel that are due for this care via pre-completed forms for each member or patient.

Once the annual comprehensive exam is completed, submit the Patient Assessment Form via email to **RAFWorksheet@evolenthealth.com** or fax to **202-379-7826**, and bill CPT code 99429 for the visit. You will receive reimbursement for the visit and PAF Form completion and submission.

Laboratory Services can be submitted in addition, and will be reimbursed at your contracted rate.

Copayment, coinsurance and deductible amounts for MedStar Medicare Choice Members, if any, are waived for these services. Modifier 25 is not required.

IMPORTANT NOTE: If the patient has an illness that needs to be treated at the time of the annual exam, you can bill the appropriate additional CPT code for reimbursement. It is important to highlight that a copay would apply for the "sick" visit.

Proactive Care

Proactive care is a coordinated approach aimed at helping close gaps in care by supporting practices with timely, actionable reports and coordinating with care advisors, who target outreach to patients. Gaps in care are

specific elements of care, based on a patient's condition, that are needed but have not been addressed and/or documented. For example, patients with diabetes need an HbA1c.

Proactive care will work in tandem with RAF processes to ensure the accuracy of patient information so that patients receive the right level of care and support.

Proactive care is a component of our progressive approach to delivering the right care to the patients in your offices. It also provides opportunities to close gaps in care by identifying patient needs at an earlier stage. Proactive care measures are derived from HEDIS® standards and Stars metrics. There is a direct linkage between closing gaps in care and improved HEDIS and Star rating.

Physicians play a critical role in closing gaps in care. To the degree that health plans can impact provider performance, they will achieve a competitive advantage. We ask that you address your members' gaps in care during every patient visit.

We look forward to continuing to work together with you. If you have any questions, please contact us at **855-222-1041**.

Provider OnLine – Your Secure Provider Portal

Register for Online Claims Look up

MedStar Select and MedStar Medicare Choice want to ensure that you have the resources and information necessary to execute your work as effortlessly and timely as possible. For this reason, we have created Provider OnLine.

What is Provider OnLine?
Provider OnLine is an online portal that only MedStar Select and MedStar Medicare Choice physicians, hospitals and care practitioners have access to. This tool allows you to view information about patient claims and benefit information.

How Do I Register for Provider OnLine?

1. Go to **MedStarProviderNetwork.org**.
2. Click on "Complete the New User Registration" icon under "Provider Login."
3. Enter the primary account administrator applicant information by clicking on the icon and then click "Submit Request" (this is where you will create your user id and password information).
4. On the next screen, you will be prompted to enter the practice information, including practice name, address, phone, and fax number, along with the practice's tax ID number, and then click "Submit Request." **Note: Only one practice address needs to be entered for each tax ID.**
5. Once steps one through four are complete, add the secondary account administrator applicant and click "Submit Request."

Once your office has supplied all of the requested information, you will see a notice that your request has been submitted for review

and you will receive an email notification when it has been processed. Please allow up to one business day for the request to complete.

Benefits of Using Provider OnLine?
Provider OnLine gives physicians access to claims and benefit information that they would otherwise need to call provider services for. This reduces the time it takes to perform daily administrative tasks and allows for more time with the patient.

This secure online service allows providers to:

1. Check member eligibility and benefits.
2. Submit claims for reimbursement.
3. Check on the status of a claim.
4. Send and receive messages to communicate with MedStar Select and MedStar Medicare Choice provider services representatives.

Please contact Provider Services at **855-222-1042** with further questions regarding claims, eligibility inquiries, member benefits, directory, and web support.

MedStar Medicare Choice Office Materials

Do you have patients that are interested in MedStar Medicare Choice? Want additional materials to help explain the Medicare Advantage plans?

MedStar Medicare Choice can provide your office with materials that can help you explain the different types of Medicare Advantage plans that may fit your patients' needs.

Did You Know?

MedStar Medicare choice offers two Special Needs Plans. A Special Needs Plan (SNP) is a Medicare Advantage coordinated care plan designed to provide targeted care and services to individuals with unique needs. The special needs plans are:

- C-SNP (Chronic SNP): Available to individuals with one or more severe or disabling chronic conditions as specified by CMS (Centers for Medicare & Medicaid Services). Individuals must be enrolled with Medicare Parts A and B. Our Chronic Condition special needs plan is available for those with diabetes and/or chronic heart failure.
- D-SNP (Dual Eligible SNP): Available to individuals who qualify for both Medicare and Medicaid.

Patients who qualify for these SNPs may be eligible for Special Enrollment Periods (SEP) per CMS. An SEP is a chance for beneficiaries to make changes to a Medicare Advantage and Prescription Drug plan when certain life events occur, such as a new chronic condition diagnosis or being eligible for Medicaid in addition to Medicare.

Outpatient Rehabilitation Services

Outpatient rehabilitation services, including medically necessary physical therapy, occupational therapy and speech therapy, are covered benefits for MedStar Medicare Choice and MedStar Select plans. These services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices and Comprehensive Outpatient Rehabilitation Facilities (CORFs). Refer to the Summary of Benefits posted at **MedStarProviderNetwork.org** to determine the applicable copay or co-insurance, 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 Medicare Choice and MedStar Select; however, coverage restrictions do apply. In addition to the Summary of Benefits, please refer to the policies posted on **MedStarProviderNetwork.org** (MP.059 and PAY.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.

HIPAA - Notice of Privacy Practices

All MedStar Select and MedStar Medicare Choice health plan policies and procedures include information to make sure the plan complies with the Health Insurance Portability and Accountability Act (HIPAA) regulations and the Gramm-Leach-Bliley Act. Hospitals and providers subject to HIPAA are trained to understand their responsibilities under these privacy regulations, as is the staff at MedStar Select and MedStar Medicare Choice. Both MedStar Select and MedStar Medicare Choice have incorporated measures in all of their departments to make sure potential, current and former members' personal health information, individually identifiable health information and personally identifiable financial information are maintained in a confidential manner, whether that information is in oral, written or electronic format.

MedStar Select and MedStar Medicare Choice employees may use and disclose this information only for those purposes permitted by federal legislation (for treatment, payment and healthcare operations); by the member's written request; or if required to disclose such information by law, regulation or court order. A form authorizing the release of personal health information is available from MedStar Select and MedStar Medicare Choice's Member Services department or from the MedStar Select and MedStar Medicare Choice website. This form complies with the core elements and statements required by HIPAA privacy rules. This form must be completed, signed and returned to MedStar Medicare Choice before it will release information.

All members receive MedStar Select or the MedStar Medicare Choice health plan's privacy statement and notice of MedStar Select or MedStar Medicare Choice health plan privacy practices in their welcome kit materials. Members also receive a copy of the privacy information annually. These documents clearly explain the members' rights concerning the privacy of their individual information, including the processes that have been established to provide them with access to their protected health information and procedures to request to amend, restrict use and receive an accounting of disclosures. The documents further inform members of MedStar Select and MedStar Medicare Choice's precautions to conceal individual health information from employers. MedStar Select and MedStar Medicare Choice's Notice of Privacy Practices are separate and distinct from the Notice of Privacy Practices providers are required to give to their patients under HIPAA. Visit **MedStarProviderNetwork.org** to view the MedStar Medicare Choice Notice of Privacy Practices.

Referrals 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 and MedStar Medicare Choice 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 or through a prescription. 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 duplicate 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 should call Medical Management at **855-242-4875** to obtain an authorization for services to be rendered by a nonnetwork provider. Failure to obtain an authorization will result in claims denials.

MedStar Medicare Choice Pharmacy Benefits

The pharmacy benefits manager for MedStar Medicare Choice is Evolent Health. A directory of participating pharmacies, the formulary, and prior authorization forms are available at **MedStarProviderNetwork.org**. Please utilize these resources to determine if the prescribed drug is on the current formulary, if a prior authorization form is required, there are quantity limits, or if step therapy is required. If your patient must take a nonformulary medication, an exception may be available.

To request an exception, complete the nonformulary exception form, posted on **MedStarProviderNetwork.org** under Pharmacy Prior Authorization forms. Please remember, if approved, the medication will be tiered as nonpreferred and may still incur significant costs for the patient. Please call Evolent Health at **855-266-0712** with questions.

Obtaining vaccines:

Medicare beneficiaries must receive most of their vaccinations from a pharmacist at a pharmacy (mandated by the Medicare Part D benefit). If a Medicare beneficiary receives a vaccine that is covered under the Medicare Part D benefit in a physician's office rather than at a pharmacy, the member is responsible for the cost of the drug and the administration of the drug. In this instance, the Medicare beneficiary would have to submit for reimbursement from their Medicare Part D plan administrator. Exception: Influenza, Pneumonia and Tetanus (following an injury) are covered through the member's medical benefit and can be administered at and billed by a pharmacy, a physician's office or an ER.

MedStar Medicare Choice 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 of $5,500 to $11,000 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.

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. Certain drugs are covered under the medical benefit and not the pharmacy benefit and may require prior authorization. In these situations, the drugs would be administered in your office instead of the member picking the drug up at the pharmacy. Please reference the prior authorization list on **MedStarProviderNetwork.org** or call Provider Services at **855-266-0712**. 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.

Obtaining Vaccines:

MedStar Select members get their vaccines at any in-network pharmacy. The pharmacy can administer and bill for both the cost of the drug and the administration of the drug through the member's pharmacy benefit. 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:

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

Updated Policies

MedStar Select and MedStar Medicare Choice will be periodically updating medical and pay policies. To ensure that our providers are aware of any changes, all updated policies will be listed in the quarterly newsletter. To view all policies—new and old—visit **MedStarProviderNetwork.org** and click on the MedStar Select or Medicare Choice policies.

MP Medical Policies (Prior Authorization)	Comments
PA-204 Genetic Test Whole Genome-Exome Sequencing	**New prior authorization policy**
PA-057 Acupuncture for Nausea and Vomiting	**Retired policy; medical payment policy created**
PA-059 Chiropractic Services and Adjunctive Procedures (Children Under 13)	**Retiring current version of policy. Replacing with new policy specific to MedStar benefits**
PA-010 DME	Updated configuration to pend less than $500 without an authorization
PA-012 Microprocessor Controlled Knee Prostheses	Mostly wording and formatting changes
PA-018 Gene Expression Testing for Breast Cancer	Mostly wording and formatting changes, update to limitations
PA-049 Dental Anesthesia	Added one code
PA-055 Molecular Susceptibility Testing for Breast and Ovarian Cancer	Addition to BRCA and BART indications, wording and formatting changes
PA-060 Outpatient Mobile Real Time Cardiac Surveillance Systems	Mostly wording and formatting changes
PA-066 High Frequency Chest Wall Oscillation Devices	Wording clarification changes to indications, added HCPCS codes and modifiers
PA-073 Wheelchair Seating Options	Mostly wording and formatting changes
PA-074 Wearable Cardiac Defibrillator	Changes to indications and limitations, addition of two codes, wording and formatting changes
PA-088 Transcatheter Aortic Valve Implantation (TAVI)	Added Pulmonary valve, added CPT codes
PA-096 Esophagogastroduodenoscopy	Update to indications, addition and removal of codes
PA-097 Molecular/Genetic Testing	Wording clarification changes to indications, added 1 CPT code
PA-200 Air Ambulance	Updated configuration to ensure all emergent air ambulances require prior auth and all nonemergent are reviewed
MP-134 Acupuncture (New)	**New medical payment policy**
MP-095 OVA1 Test (Medicare Only)	**Retired policy**
MP-009 Presbyopia Correcting Intraocular Lenses (PIOLs) and Astigmatism Correcting Intraocular Lenses (ACIOLs)	Mostly wording and formatting changes

MP-011 Surgical Dressings and Wound Care Supplies	Addition to limitations, wording and formatting changes
MP-016 Temporomandibular Joint Disorders	Update to codes (most just descriptions of codes), formatting and wording changes
MP-017 Infertility - Diagnosis	Changes to indications and limitations
MP-031 ZOSTAVAX Vaccine	Additions to limitations, background updated
MP-033 - HPV Vaccine	Indications now include GARDASIL-9 to align with ACIP
MP-038 Septoplasty - Rhinoplasty	Addition to indications, coding changes (added CPT, ICD 9 and 10 codes)
MP-052 Bladder Tumor Antigen Test	Added ICD 9 and 10 codes
MP-056 Management of Unlisted/Nonspecific HCPCS/CPT Codes	Changes to indications, removal of specific codes and replaced with general statement that all unlisted codes subject for clinical review
MP-065 Telemedicine	Update to indications, added several codes, wording and formatting changes
MP-075 E-visits	Additions to list of covered services for E-visits
MP-083 Skin Substitutes - Human Skin Equivalents	Changes to indications, added and removed codes
MP-091 - IVUS	2016 coding changes (removed deleted codes, inserted 2016 replacements)
MP-094 Transcutaneous Electrical Nerve Stimulators (TENS)	Wording clarification and additions to indications, additions to Medicare variations, added ICD 9 and 10 codes
MP-099 Autism Spectrum Disorders - Management	Minor changes to indications and limitations, added one code
MP-100 AlloMap Molecular Expression Test	Mostly wording changes and added codes.
MP-104 Vision Therapy	Added ICD 9 and 10 codes
MP-112 Laryngeal Injections for Vocal Cord Augmentation	Added CPT and HCPCS codes
MP-114 High -Resolution Anoscopy (HRA)	Mostly wording and formatting changes
MP-115 Vysis ALLK Break Apart FISH Test for the Selection of Xalkori	Changes to indications - changed to general genetic testing for lung cancer instead of just Vysis ALK Fish Test (added tests), added codes
MP-127 Magnetic Resonance Spectroscopy	Changes to limitations, added and removed codes
MP-128 Thyroid Nodule Testing	Added and removed ICD 9 and 10 codes
MP-129 Posterior Tibial Nerve Stimulator (PTNS) for Urinary Incontinence	Added ICD 9 and 10 codes
MP-131 Low Dose CT for Lung Cancer	2016 coding changes (removed deleted codes, inserted 2016 replacements)

Screening 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.

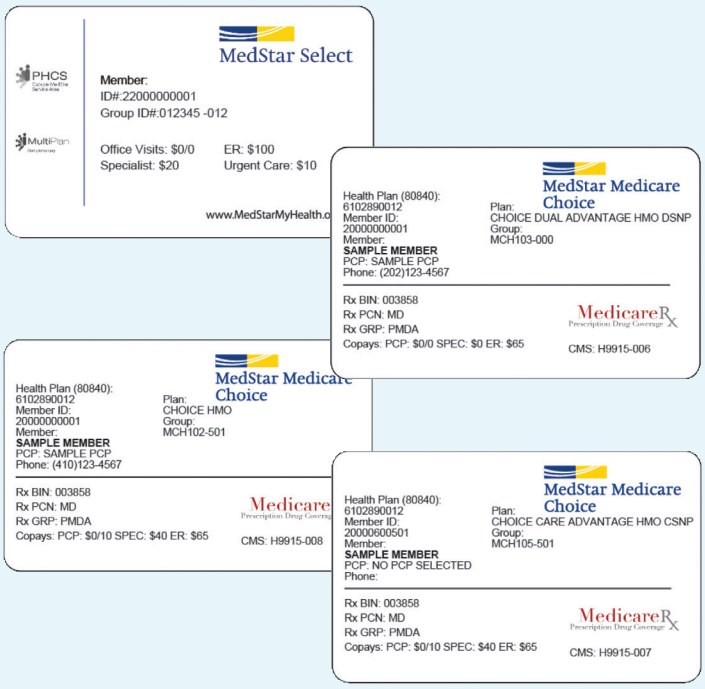
Many factors may increase a patient's blood pressure and it is recommended that members with a high blood pressure reading be asked if they are under treatment for hypertension. If they are not, the patient should be encouraged to schedule an appointment with his or her primary care provider to screen 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 **msfcproviderrelations2 @medstar.net** or **800-905-1722, option 5**.

Membership Cards

Each MedStar Select and MedStar Medicare Choice 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**.



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