Third Quarter 2021

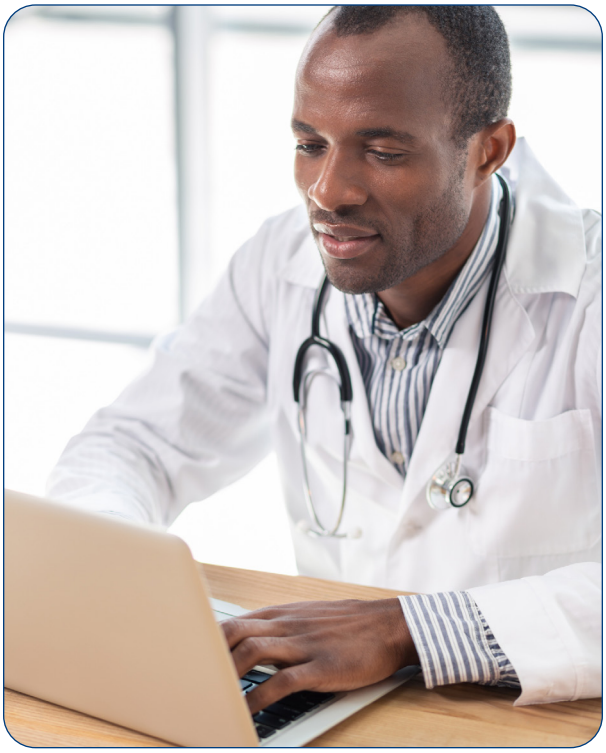
MedStar Health

MedStar Select Provider Newsletter

Learn more about provider credentialing and recredentialing.

Accurate and timely provider data is essential to keeping MedStar Select's credentialing system running smoothly. MedStar Select's credentialing system helps to develop directories, and assists with paying claims. Collecting and maintaining accurate provider data can be challenging which is why we rely on providers to keep their CAQH online application up to date. In addition, MedStar Select providers are required to comply with the following:

- Providers shall immediately notify MedStar Select of any changes in the status of licensure (i.e., suspended, revoked, surrendered, new licensure number, etc.).
- Providers shall maintain a valid and current license to practice at all times.
- DEA or CDS Certificates applies to providers who are qualified to write prescriptions, and providers must also maintain a valid and current certificate at all times.
- Every 120 days practitioners must re-attest that their CAQH online application is correct.
- Providers will notify MedStar Select of the suspension, loss or reduction of hospital privileges.



CAQH Benefits to Providers

- Free service to providers
- Easy to use
- Enter, submit, and store all data electronically
- Eliminates the need for time-consuming paper forms
- Enhanced security features help you maintain total control of your information
- Re-attest in minutes
- Updated information is immediately available to organizations authorized by the provider
- Upload supporting documents directly into CAQH ProView to eliminate the need for manual submission, and to improve the timeliness of completed applications

MedStar Select annual enrollment begins soon!

The annual enrollment period for MedStar Select will begin on Oct. 26 and run through Nov. 15, for benefits beginning on Jan. 1, 2022. The MedStar Select Plan offers comprehensive medical coverage for MedStar Health associates and their dependents through the MedStar Select Provider Network. This network consists of not only MedStar-employed providers, but also a full complement of contracted community providers. The plan offers in-network and out-of-network benefits. We recommend you select a primary care physician (PCP) to coordinate your care. Referrals are not necessary for specialty care.

For more information, or to confirm if you are in the MedStar Select Provider Network, visit **MedStarMyHealth.org** or call **855-242-4872**.

Welcome new providers to MedStar Select.

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

- **Qi Cao (**Internal Medicine, Baltimore, Baltimore County)
- **Sherman Podiatry PA (**Podiatry, Baltimore, Baltimore City)
- **Spring Pediatrics Inc (**Pediatrics, Silver Spring, Montgomery County)
- **Ten Oaks Health and Wellness (**Chiropratic Medicine, Glenelg, Howard County)

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

- Durable Medical Equipment/ Infusion/Injectables: **MedPlus Infusion Pharmacy LLC**
- Laboratory: **Dianon System Esoterix Genetics Laboratories, Esoterix Inc**

About documentation and coding audits.

Throughout each year, we conduct focused and routine chart audits. If a provider's office is selected for review, we will contact the physician's office and request copies of the medical records for specific dates of services for our members. The records are reviewed by our compliance analyst and each code that was billed and paid is analyzed. Many of our reviews focus on E/M visits. Providers should ensure that the medical record documentation supports the level of service billed, coding, and documentation requirements for time-based procedures are met, and the services performed meet medical necessity. Medical necessity of a service is determined through various factors, including, but not limited to:

- Clinical judgment
- Standards of practice

Chief Complaint:

- Any acute exacerbations or onsets of medical conditions or injuries
- The acuity of the patient
- Multiple medical co-morbidities
- The management of the patient for that specific date of service. The volume of documentation should not be the primary influence upon which a specific level of service is billed.

To avoid payment retractions, the documentation in the medical records must be legible, dated, signed by the provider, and support the CPT code that was billed on the claim. If you have any questions regarding chart audits, please contact Provider Relations at **800-905-1722, option 5**.

Refunds
If MedStar Select has paid in error, providers may return the check or write a separate check from their account for the full amount paid in error. Providers should include a copy of the remittance advice, supporting documentation noting the reason for the refund and the explanation of benefits (EOB) from other insurance carriers, if applicable. Refunds should be sent directly to the General Accounting department at this address:

Attn: General Accounting
MedStar Select
600 Grant St.
24th Floor
Pittsburgh, PA 15219

Overpayment
If MedStar Select has paid in error and the provider has not sent a refund or returned the check, money will be deducted from future claims paid. The related claim information will be shown on the remittance advice as a negative amount. Providers will be notified of overpayment and/or retraction of funds. Providers are required to report overpayments to MedStar Select if errors are identified prior to receiving plan notification.

Let's decrease emergency department utilization as a team.

MedStar Health is looking to reduce emergency room (ER) utilization for minor illnesses or injuries. As providers, you can have a meaningful impact on accomplishing this goal. When you see a MedStar Select member, please discuss with them that there are other options to being treated for minor illnesses or injuries.

- Encourage the member to contact you or your office first before going to the ER unless it is life threatening.
- If your office provides extended office hours or urgent care services, please educate our members about this available option and explain the benefits of not sitting in the ER.
- Encourage the use of an urgent care facility when appropriate like MedStar PromptCare, Patient First, Express Care or Righttime Medical Care. Explain to the member that it's more convenient because of the decreased wait time.
- Help us educate our members of the availability of MedStar eVisit. MedStar Select members have free 24/7 video access to trusted medical providers from their tablet, smartphone, or computer through MedStar eVisit.

Thank you for partnering with us in educating our members on appropriate use of the ER.

Use the Provider OnLine portal.

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 **855-222-1042**.

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**.

How high dollar claims are verified.

MedStar Select has a process to review high dollar claims prior to payment to verify accuracy of reimbursement. A high dollar claim is defined as any claim with a total payment amount that is determined to be equal to or greater than $25,000. Once claims are received via electronic or paper format, those exceeding the dollar threshold amount are held for the Quality Assurance department to complete a comprehensive review prior to payment distribution.

Within two (2) business days of receipt, the representative from the Quality Assurance department reviews the high dollar claim for accuracy. After the claim is reviewed, remarks are added stating if corrections to the claim are required prior to the claim being released. If the claim is correct, it is routed back to the Claims department to be released if the total payment amount is less than $100,000.

Claims $100,000 or greater are routed back to the Claims department to be released by a manager. If corrections are needed, it is routed back to the Claims department for corrections prior to release. A small subset of claims also undergo a coding and/or clinical review. The claims forwarded for review include (but are not limited to) when the allowed amount exceeds the billed amount on the claim; or when pharmacy or supply charges seem unusually high.

These reviews could result in a request for medical records to support the services billed, which must be received in order to approve payment. Three outreach attempts will be made. If the information is not received after three attempts, the claim could be denied. Audits are performed on a sample of claims on both a weekly and monthly basis to validate that high dollar claim reviews are being performed accurately and appropriately. For more information on the high dollar claim review process, please contact Provider Services at **855-222-1042**.

Avoid timely filing denials.

Quite often, claims are denied because they were not submitted within the required amount of time. A claim must be received by MedStar Select within 180 days from the date of service. Claims submitted after 180 days will be deemed as untimely and will not be paid.

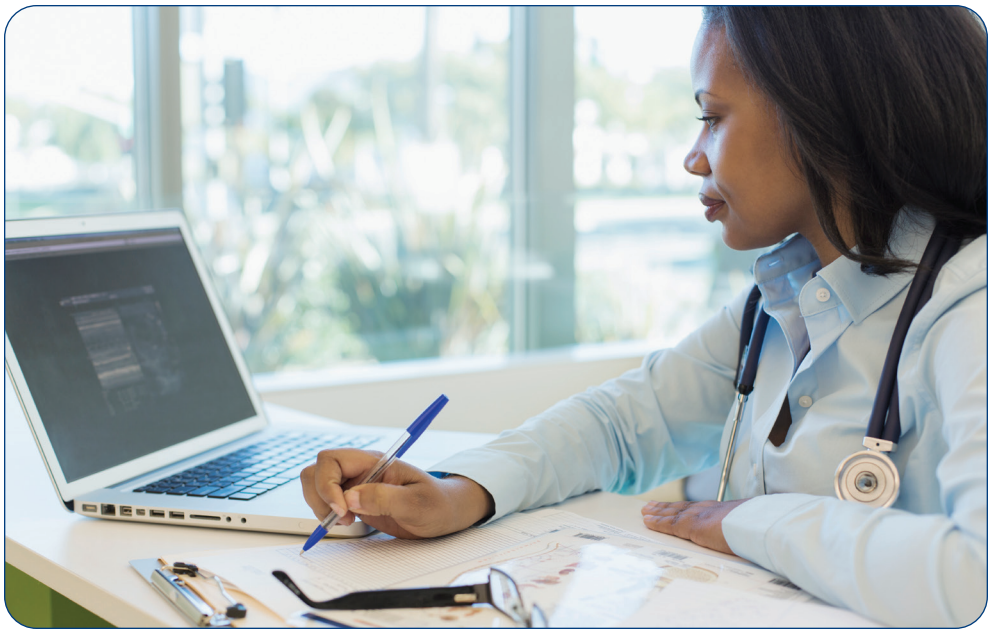
There is an exception when coordination of benefits is involved. For example: If a member has both Medicare (primary carrier) and MedStar Select (secondary carrier), the filing must occur within 180 days from the date of the Medicare explanation of payment (EOP) to be considered timely. It is always required that the provider submit that EOP with the claim once they receive it. When a claim is submitted, please retain the EOP as your proof of timely filing. It is critical for providers to retain EOPs since this is the only acceptable proof that a claim has been filed in a timely manner.

Billing system printouts are not acceptable proof that a claim was filed in a timely manner. Providers should make every effort to submit claims as soon as possible. This allows providers additional time to submit corrected new claims within the required 180 day period.

For claims inquiries, including verifying receipt of a claim or inquiring about the status of a claim, call Provider Services at **855-222-1042** or log on to the provider portal at **MedStarProviderNetwork.org**. For provider online log in requests, call Provider Services at **855-222-1042** or email provider_support@togetherforyourhealth.com.

Find it on the web.

The MedStar Select provider website at **MedStarProviderNetwork.org** includes resources such as:



- Provider Directory
- Provider Manual
- Medical Policies
- Payment Policies
- Pharmacy Formulary
- Benefits Booklet
- EDI Documents
- Reason Codes
- Quick Reference Guide [frequently updated]
- Medical Management Forms
- How to Become a Participating Provider
- Ancillary Provider Interest Form
- MedStar Newsletter
- Contact Us

Submitting MedStar Select provider appeals.

Please make sure to submit all provider appeals in writing to the correct address for MedStar Select. The correct address is listed below.

Provider appeals sent to the incorrect address could result in the appeal not being received by MedStar Select, or could delay processing.

MedStar Provider Appeals
PO Box 269
Pittsburgh, PA 15230
Fax: 855-435-8762

Understand MedStar Select site evaluations.

Site surveys are completed for all PCPs and specialists at the time of initial credentialing. If a member complaint is received about the physical condition of the provider office, a follow-up site audit will be performed.

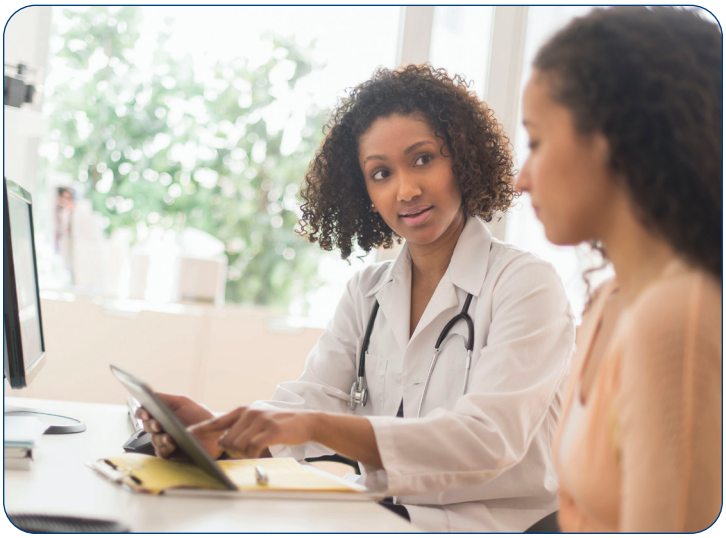
New provider sites and site additions also require a site evaluation after Provider Relations is notified of the change or addition.

If you have any questions or comments regarding minimum standards for site evaluations, please contact your provider representative at **800-905-1722, option 5**.

Care for high-risk patients at $0 cost.

Care advising offers personalized, one-on-one support to your patients who need extra help managing their health. Care advising uses evidence-based programs and proactive care delivery to help improve patient outcomes and reduce costs.

Informed by the patient's primary care team, care advising serves as a complement of care outside of the office setting. Care advisors, who are registered nurses, work with patients across a continuum of care management programs, including:



- Transition care, which focuses on patients who are at high risk for hospital readmissions
- Complex care, which focuses on patients likely to incur a disease-specific admission
- Maternity care, which offers support to patients during their pregnancy and post-partum

What Care Advisors Do:

- Help patients identify their personal health goals and create a care plan to achieve those goals
- Work closely with you to review your patient's care plan and monitor progress
- Regularly check on patients' progress, care plan adherence, and assess ongoing needs
- Help patients get doctor visits and screenings scheduled
- Attend doctor visits where appropriate
- Find appropriate support services close to patients' home or work
- Help with medication questions, food choices and social needs

Working on behalf of MedStar Health and the patient's primary care doctor, care advisors will engage eligible patients by phone or in person. Patients who choose to participate will work with the same care advisors until their goals are achieved, which gives the care advisors greater opportunity to get to know each patient's unique healthcare needs.

At this time, MedStar employees and their dependents covered by MedStar Select may be eligible for care advising services. Only those individuals who are identified as in need of additional support–through physician referral and a comprehensive assessment of health data–will be contacted to participate.

If you believe you have a patient who may be appropriate for care advising services, contact our care advising line: **888-959-4033**.

Know how to submit claims properly.

Claims must be submitted within 180 days of the date of service. Providers may submit a claim on paper, through a clearinghouse, or directly through the online provider portal.

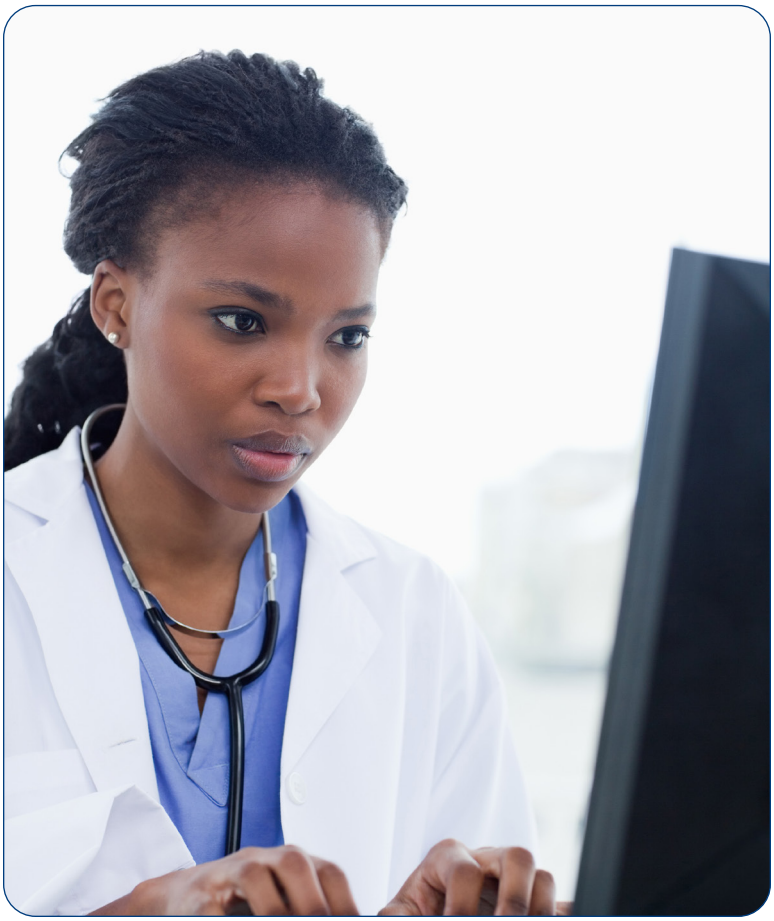
- Paper claims should be mailed to:

  MedStar Select Claims
  PO Box 1200, Pittsburgh, PA 15230-1200

- Electronic claims are accepted from clearinghouses, such as Emdeon, Relay Health, and Allscripts.

The payer ID for MedStar Select claims is 251 MS.

- Direct submission of claims for MedStar Select is available at MedStarProviderNetwork.org. Providers must sign up for a login to view eligibility, claims, and other patient specific information. If you have additional questions, please contact Provider Services at **855-222-1042**.



After claims are successfully submitted and received, payments are dispersed within accordance with all regulatory prompt pay guidelines. Please contact Provider Services to verify claims receipt, as well as claims status and inquiries, at **855-222-1042** or Provider Portal Support at **855-222-1043**.

Inquiries can also be made through the provider portal at **MedStarProviderNetwork.org**.

Pass-through billing is prohibited.

MedStar Select and the Maryland Department of Health prohibit pass-through billing. Pass-through billing occurs when the ordering provider requests and bills for a service, but the service is not performed by the ordering provider or those under their direct employ.

If you are a physician, practitioner, or medical group, you must only bill for services that you or your staff perform. The performing provider should bill for these services unless otherwise approved by MedStar Select.

Effectively communicate with your patients.

Many patients have little experience with medical terminology and keeping it simple makes things easier for the patient to understand. Patients who understand the information their practitioners are presenting to them about their health and treatment are more likely to follow instructions to improve their health.

To communicate effectively with patients, practitioners need to be mindful that each patient is different, so their communication techniques must be diverse as well. Providers should realize that all patients are unique, and keeping up to date with various backgrounds, cultures, social and economic issues, past history, etc., could potentially help providers better communicate with their patients on an individual level.

Encouraging patient involvement is also a great tool to bridge the communication gap between providers and patients. Providers must recognize when to call upon the help of the patient's family and friends (with the patient's permission, of course) to assist with communication and cultural differences when needed. Some educational resources include: Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS) training, CME, specialty education, and CLAS modules.

More resources can be found on the U.S. Department of Health & Human Services Think Cultural Health website at **ThinkCulturalHealth.HHS.gov**. For language barriers, providers should utilize interpretation services, as they are available.

MedStar Select members can call Member Services at **855-242-4872** to address any benefit questions. MedStar Select members may also visit **MedStarMyHealth.org** for any additional questions. Taking all of these steps will help to foster a good relationship between you and your patients.

Please confirm your office information.

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 contact Provider Relations at mfc-providerdemographics@medstar.net or **800-905-1722** to resolve.

Help us to ensure that MedStar Select has the most accurate and up to date information!

MedStar Health

5233 King Ave., Suite 400
Baltimore, MD 21237
800-905-1722 **PHONE**
MedStarProviderNetwork.com

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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.