MedStar Family Choice

DISTRICT OF COLUMBIA

Provider Newsletter

Spring 2022

In This Issue

DHCF Department of Health Care Finance

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WE ARE WASHINGTON DC GOVERNMENT OF THE DISTRICT OF COLUMBIA MURIEL BOWSER, MAYOR

MFCDC-001-042022

A message from our CMO and Directors

The MedStar Family Choice District of Columbia (MFC-DC) Provider Network and Quality Improvement teams welcome our new providers, and extend a huge thank you for all you do to care for our enrollees.

Throughout 2022, we have been, and will continue scheduling introductory meetings with our provider community. Our plan is to share recent MFC-DC enhancements and tools you may find helpful for your practice. These tools will include such things as provider performance metrics/ reports, enrollee care gap information and quality improvement resources. Our goal is to be readily available, approachable and prompt in addressing any concerns and/or questions you may have related to the care of our enrollees.

Our Provider Network and Quality Improvement teams are led by the following individuals:

Raymond K. Tu, M.D., M.S., F.A.C.R.
Chief Medical Officer
Raymond.K.Tu@medstar.net

Carl Chapman, Sr.
Director, Provider Network
Carl.L.Chapman@medstar.net

Michelle Winterstein, MSHS
Interim Director, Quality & Outreach
Michelle.Winterstein@medstar.net

Please do not hesitate to contact any of these leaders. The Provider Relations department is available to assist you as well, Monday through Friday, 8 a.m. to 5:30 p.m. at **855-798-4244** (option 2) or at **mfcdc-providerrelations@medstar.net**.

We look forward to caring for you in 2022!

Our provider community at work

Featuring: Mary's Center for Maternal and Child Care

This is MedStar Family Choice District of Columbia's (MFC-DC) inaugural article where we highlight the work of our provider community. In each provider newsletter going forward, we will write about a provider and the important work they do caring for our enrollees. MFC-DC greatly appreciates our providers as they work to improve health outcomes and we want to acknowledge and support these efforts.

In this feature, we are highlighting the work of Mary's Center for Maternal and Child Care. Mary's Center was established in 1988 to care for Latin American immigrants in the District of Columbia and surrounding area. Mary's Center has now expanded to serve the broader community. They now serve over 60,000 patients from 50+ countries. Mary's Center is one of the largest healthcare providers in the MFC-DC network. Their core services are: primary care; OB/GYN services; behavioral health services, and dental care. They have five full-service community health centers; 26 school-based mental health centers; two Senior Wellness Centers and a Public Charter School co-located at three health centers.

Mary's Center has been very instrumental in addressing the COVID-19 pandemic. Since March 2020, they have administered over 45,000 COVID-19 tests. These efforts have allowed them to identify pregnant participants who tested positive for COVID-19 and provide appropriate care. They have also administered over 26,500 vaccines with more than 200 since March 1, 2022.

On April 29th, the Medical Society of the District of Columbia will honor Mary's Center at their **2022 Capital Healthcare Honors**. This event is a celebration of the District's healthcare heroes. Mary's Center will receive the "John Benjamin Nichols Award" in recognition of their contributions to improving the health of the District of Columbia, especially during the pandemic. MFC-DC is proud to partner with a healthcare organization like Mary's Center to help our enrollees get access to care.

Enrollees can eat healthy and experience a community oasis

Enrollees will have increased access to healthy food options and education through our collaboration with DC Greens. We congratulate DC Greens' grand opening of The Well at Oxon Run under the leadership of Director Jaren Lockridge, also the Chairwoman of The Ward 8 Health Council.

The Well at Oxon Run is a one-acre jewel nestled in Oxon Run Park featuring seasonal crop production, pick-your-own-flower gardens, a farm stand, an orchard with chickens, a greenhouse, herb and pollinator gardens, and a large youth garden with an outdoor classroom. This visionary space will be a sustainable source of healthy food for schools, community members, and area restaurants. Seniors and youth alike will enjoy seedlings-to-plate education in this new gathering space for the Ward 8 community.

The first planting season is scheduled to kick off this Spring. Please share this information with our enrollees. For more information please visit **DCGreens.org/thewell**.

Formulary updates for providers

MedStar Family Choice District of Columbia (MFC-DC) has a Pharmacy and Therapeutics Committee that meets quarterly. During our February 2022 meeting, formulary changes were made as listed below for DC Healthy Families and DC Healthcare Alliance. **These changes become effective April 1, 2022 unless indicated otherwise.**

Additions	• LOXAPINE (effective 1/19/2022) • INSULIN GLARGINE-YFGN • FIRMAGON (degarelix) • TRUXIMA (rituximab-abbs) **Note:** *Truxima is the preferred agent and is a biosimilar for Rituxan, except Truxima is not indicated for use in pediatrics. Claims for Rituxan will not be paid for without prior approval when used in both outpatient and inpatient settings.*
Additions with Prior Authorization*	• APRETUDE (cabotegravir extended-release) • EMGALITY (galcanezumab-gnlm) • ENSPRYNG (satralizumab-mwge) • LIVTENCITY (maribavir) • RITUXAN (rituximab) • RITUXAN HYCELA (rituximab/hyaluronidase human) • SCEMBLIX (asciminib) • TAVNEOS (avacopan) • VOCABRIA (cabotegravir) • VOXZOGO (vosoritide) • VYVGART (efgartigimod alfa-fcab) *Please see the PA Table on the MFC-DC website for details of the requirements for approval and guidance on submission of clinical information.*
Removals	None
Removal of Prior Authorization	• FREESTYLE LIBRE (effective 2/14/2022) • FREESTYLE LIBRE SENSOR (effective 2/14/2022) • FREESTYLE LIBRE READER (effective 2/14/2022)
Managed Drug Limitations and Step Therapy**	• VYVANSE (lisdexamfetamine) – Added to Formulary with Step Therapy

The 2022 MFC-DC Formulary and updates are available on the Pharmacy page of our website at **MedStarFamilyChoiceDC.com/providers/pharmacy**. For more information, please call us at **855-798-4244** (select option 2 for Provider and then option 2 for Provider Relations)

** Details of the Prior Authorization Criteria are on the website in the Prior Authorization Table.*
*** Details of the Step Therapy Criteria are on the website in the Step Therapy Table.*

Produce Rx for diet-related chronic illnesses

Produce Rx, sponsored by DC Greens and Giant Food, allows medical professionals to prescribe fresh and frozen fruits and vegetables to patients experiencing diet-related chronic illnesses. The program goal is to increase access to nutritious foods for participants by providing $240 per month, valid for 90 days, to use at selected Giant Food grocery stores. To learn more about prescribing Produce Rx visit **dcgreens.org/produce-rx**.
For information to share with enrollees, visit **dcgreens.org/prx-customers**.

Know the rights and responsibilities of our enrollees

Enrollees have certain rights and responsibilities. These rights and responsibilities are reviewed annually and can be found in our Enrollee Handbook and Provider Manual; both can be found on our website at **MedStarFamilyChoiceDC.com**. Please contact us at **855-798-4244** (select option 2 for Provider and then option 2 for Provider Relations) with any questions or comments you many have, or to request a hard copy of all materials.

As a MedStar Family Choice District of Columbia (MFC-DC) enrollee, you have the right to:

- Know that when you talk with your doctors and other providers it's private.
- Have an illness or treatment explained to you in a language you can understand.
- Participate in decisions about your care, including the right to refuse treatment.
- Receive a full, clear and understandable explanation of treatment options and risks of each option so you can make an informed decision.
- Refuse treatment or care.
- Be free from any form of restraints or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Can see and receive a copy of your medical records and request an amendment or change, if incorrect.
- Receive access to healthcare services that are available and accessible to you in a timely manner.
- Choose an eligible PCP/PDP from within the MFC-DC network and to change your PCP/PDP.
- Make a Grievance about the care or services provided to you and receive an answer.

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- Request an Appeal or a Fair Hearing if you believe MFC-DC was wrong in denying, reducing or stopping a service or item.
- Receive Family Planning Services and supplies from the provider of your choice.
- Obtain medical care without unnecessary delay.
- Receive a second opinion from a qualified healthcare professional within the network, or, if necessary, to obtain one outside the network, at no cost to you.
- Receive information on Advance Directives and choose not to have or continue any life-sustaining treatment.
- Receive a copy of the MFC-DC Enrollee Handbook and/or Provider Directory.
- Continue treatment you are currently receiving until you have a new treatment plan.
- Receive interpretation and translation services at no cost.
- Refuse oral interpretation services.
- Receive transportation services at no cost.
- Get an explanation of prior authorization procedures.
- Receive information about MFC-DC's financial condition and any special ways we pay our doctors.
- Obtain summaries of customer satisfaction surveys.
- Receive MFC-DC's "Dispense as Written" policy for prescription drugs.
- Receive a list of all covered drugs.
- Be treated with respect and due consideration for your dignity and right to privacy.
- Receive health care and services that are culturally competent and free from discrimination.
- Receive information, including information on treatment options and alternatives, regardless of cost or benefit coverage, in a manner you can understand.
- Exercise your rights, and that the exercise of those rights does not adversely affect the way we, our providers, or the Department of Health Care Finance treats you.
- Request a Fair Hearing with the District of Columbia after an Adverse Determination is made as a result of an Appeal.
- Request that ongoing benefits be continued during an Appeal or state Fair Hearing however, you may have to pay for the continued benefits if the decision is upheld in the Appeal or Hearing.
- Receive other information about how MFC-DC is managed including the structure and operation, as well as physician incentive plans.
- Receive information about MFC-DC, its services, its practitioners and providers and enrollee rights and responsibilities.
- Make recommendations regarding the organization's enrollee rights and responsibilities policy.
- A candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.

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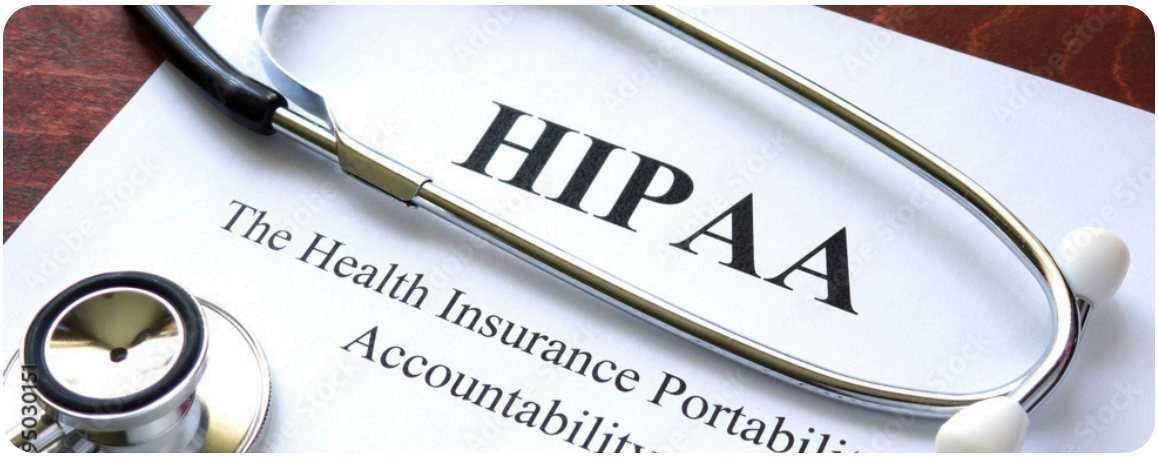
As a MedStar Family Choice District of Columbia (MFC-DC) enrollee, you are responsible for:

- Treating those providing your care with respect and dignity.
- Following the rules of the DC Medicaid Managed Care Program and MFC-DC.
- Following instructions, you receive from your doctors and other providers.
- Going to scheduled appointments.
- Telling your doctor at least 24 hours before the appointment if you must cancel.
- Asking for more explanation if you do not understand your doctor's instructions.
- Going to the Emergency Room only if you have a medical emergency.
- Telling your PCP/PDP about medical and personal problems that may affect your health.
- Reporting to Economic Security Administration (ESA) and MFC-DC if you or a family Enrollee have other health insurance or if you have a change in your address or phone number.
- Reporting to Economic Security Administration (ESA) and MFC-DC if there is a change in your family (i.e. deaths, births, etc.).
- Trying to understand your health problems and participate in developing treatment goals.
- Helping your doctor in getting medical records from providers who have treated you in the past.
- Telling MFC-DC if you were injured as the result of an accident or at work.
- Informing your provider and MFC-DC if you have any other health insurance coverage.
- Being on time for appointments and notifying providers as soon as possible if you need to cancel an appointment.
- Showing your enrollee ID card when you check in for every appointment.
- Reporting lost or stolen enrollee ID cards to MFC-DC.
- Calling MFC-DC if you have a problem or a complaint.
- Working with your Primary Care Provider (PCP) to create and follow a plan of care that you and your PCP agree on.
- Asking questions about your care and letting your provider know if there is something you do not understand.
- Updating the District of Columbia Government (ex: DHCF, ESA) if there has been a change in your eligibility status.
- Providing MFC-DC and our providers with accurate health information in order to provide proper care.
- Telling your PCP as soon as possible after you receive emergency care.
- Informing your caregivers about any changes to your Advance Directive.
- Supplying information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.



Ensure patient privacy and security

The HIPAA Privacy and Security Rules regulate what can and cannot be done with certain types of health information. In addition to HIPAA, providers must comply with other applicable federal, state, and local laws which govern privacy requirements. The HIPAA Privacy Rule covers protected health information (PHI) in any medium.

The HIPAA Security Rule covers electronic protected health information (ePHI). A few simple steps can help protect patient privacy daily. These tips include:

- Do not leave PHI in areas where it can be viewed or accessed by unauthorized personnel.
- Sign-in sheets should not state the reason for the patient's medical appointment.
- Face sheets should be turned toward the wall if patient charts are outside of an examination room.
- Keep confidential conversations at a low level.
- Leave minimum necessary information regarding appointments on patients' voicemails.
- Computers/workstations should be in an area that minimizes accidental/non-authorized viewing of patient information.
- Assign strong passwords to computer systems.
- Do not share user IDs or passwords.
- Do not post passwords in or around workstations where they can be viewed easily by others.
- Always log off of computers/workstations when leaving work for a long period of time or lock computers when away from the workstation.
- Add password-protected screensavers to personal workstations.
- Protect electronically transmitted PHI through encryption and password protect electronic patient information.
- Save PHI data to the appropriate locations and in the appropriate manner so the data is backed up regularly.
- Properly dispose of any documents or papers containing PHI in shredders or special destruction boxes which is consistent with retention guidelines.

Visit the U.S. Department of Health and Human Services website at **HHS.gov** and **HealthIT.gov** for more information regarding HIPAA rules.

Cultural Diversity Training is available online

As a MedStar Family Choice District of Columbia (MFC-DC) provider, you are required to take annual trainings, and we have made it easier for you to satisfy your training requirements. The Cultural Diversity Training is available as an on-demand online course and can be taken at any time. There is no need to travel or schedule at a specific date and time at your office.

The online training is available on the MedStar Health Simulation Training & Education Lab (SiTEL) website, which delivers online education and experiential learning.

The Cultural Diversity Training link can be accessed on the Provider Resources webpage: **MedStarFamilyChoiceDC.com/Providers/Provider-Resources**

Your provider relations associate is available to fulfill your other training needs for the Provider Orientation/Provider Education training. Please contact us today, to schedule your provider education session. If you have any questions or concerns about this online training or SiTEL, please email MFC-DC Provider Relations at **mfcdc-providerrelations@medstar.net** or **855-798-4244** (select option 2 for Provider and then option 2 for Provider Relations).

Proper physician signature guidance

The purpose of a physician's signature in a medical record or operative report is to clearly identify who ordered and provided supplies or services for the patient. It also serves as a testament that the services he or she provided were accurately and fully documented, reviewed, and authenticated. Equally important, payers deny claims unsubstantiated by the service provider's signature; not just any signature or person making a signature will do.

Acceptable signatures

Each signature must be legible, and include the provider's first and last name. The signature also should include the provider's credentials (e.g., PA, MD, DO). There are acceptable methods of signing records/tests orders and findings, which include:

- Handwritten signatures or initials
- Electronic signatures usually contain date and timestamps and include printed statements, "electronically signed by" or "verified/ reviewed by," followed by the practitioner's name and a professional designation.
- Digital signatures are an electronic method of a written signature typically generated by encrypted software, allowing sole usage.

Note: Electronic and digital signatures are not the same as "auto-authentication" or "auto-signature" systems, some of which do not mandate or permit the provider to review an entry before signing. Documentation that has been "signed, but not read" is not acceptable as part of the medical record.

Also, the ordering or prescribing physician or non-physician practitioner (NPP) must make a mark or sign on a document indicating their knowledge, approval, acceptance, or obligation to services provided or certified. Additionally, electronic signatures may also include an electronic sound, symbol, or process attached to, or logically associated with, an electronic medical record. Your electronic signature:

- Must be authenticated, safeguarded against misuse and modification, and easily identifiable as electronic instead of a typed signature.
- Represents the provider who signed it. That individual bears responsibility for its authenticity. We strongly encourage physicians and NPPs to check with their attorneys and malpractice insurers when using electronic signatures as an alternate signature method.

Unacceptable signatures

Reports or records dictated and/or transcribed that do not include valid signatures finalizing and approving the documents are unacceptable and will not serve to support claims for reimbursement. At one time, signature stamps were permitted, but they are no longer recognized as valid authentication for CMS signature purposes.

Sloppy signatures – use a signature log

Providers will sometimes include a signature log in the documentation that identifies his or her initials, or an illegible signature, as the author of the documentation. The signature log might be included on the same page where the initials or illegible signature appear for each medical record, or it might be a separate document. A signature log should include the physician's printed name, full signature, and initials that appear on the document. The physicians can also list his or her credentials for further proof and validation.

The importance of self-audits

Self-audits are an important step that medical organizations of all types can take to protect themselves from potential lost revenue (or worse) by identifying coding, billing, and documentation problems before a payer does. All practices should make self-audit a part of their coding compliance program.

What self-audits can achieve

Self-audits allow you to:

- Identify fraud and improper payments
- Provide opportunities to improve documentation and patient care
- Lower the risk of an external audit
- Identify educational opportunities with your organization
- Create a vigorous culture of compliance

Spotting problem areas allows you to initiate corrective action and prevent more damaging financial repercussions later. They also allow you to identify possible missed revenue opportunities. The Office of Inspector General (OIG) recommends that a facility or provider start with a baseline audit, which should cover at least three months and should include a random selection of five to ten Medicare/ Medicaid records per professional who bills claims for Centers for Medicare & Medicaid Services (CMS) approved services.

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Auditing as opportunity

Self-audits may seem like a daunting task; however, creating a positive atmosphere around self-audits is rewarding. Self-auditing provides distinct organizational value that exceeds compliance, and should be viewed as a natural and positive process. Begin by describing your goals for self-auditing. Each organization is different, and it is recommended starting with simple goals and achieving those, first, before moving to the harder ones. For example, start with the goal of identifying improper payments using self-audit through that lens. Next move up the ladder to validating provider documentation and coder accuracy.

As you move along your self-auditing roadmap, you will naturally discover process improvements. Improved patient care, along with improved compliance, should be the goal. Working through self-audits in this phased approach helps to remove any barriers to change, and help to achieve high marks from your patients and employees alike.

Meeting OIG compliance

A key goal while working through your roadmap is to adhere to OIG compliance rules. If the OIG ever knocks at your door, not only will you have a roadmap that shows your commitment to compliance, you'll also have real self-auditing artifacts to back it up.

Here are the steps to develop and comply with the OIG self-audit requirement.

1. Determine who is accountable for specific roles within the organization.
2. Assign a strong coder who can review the medical records and bills for accuracy of the information.
3. Verify that the medical records documentation is complete and all diagnosis codes are documented and are currently being treated.
4. Set a time frame, the OIG recommends quarterly audits.
5. Determine the number of charts to be reviewed.
6. Specify the types of accounts to review. For example, for outpatient accounts you should:
   - Review ICD-10 codes;
   - Review charges (important for potential overcharging or missed revenue), and;
   - Review providers level of care and does their documentation support the level selected.
7. Reports should include all your findings: the good, the bad, and the ugly. Include educational resources so the coder and provider can improve the accuracy.
8. Meet with the coders and providers to go over the results and office education pointers.
9. Request help for guidance in interpretations of any misunderstood or unclear coding rules, regulations, and requirements.

For additional resource visit: **dhcf.dc.gov/page/provider-self-audit**.

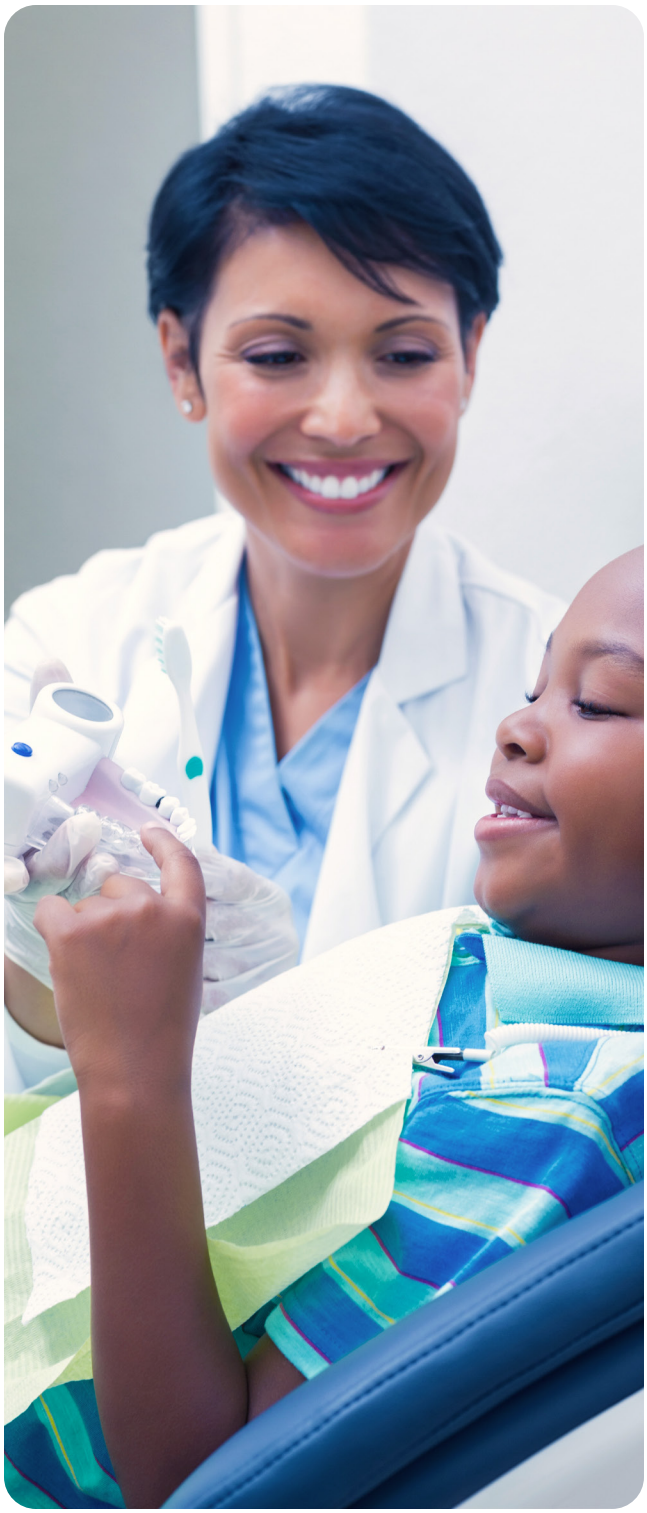
Ensure EPSDT quality of care

The District of Columbia Department of Health Care Finance (DHCF) annually evaluates the quality of care provided to Managed Care Organization (MCO) enrollees that meet criteria for HealthCheck, the District's early and periodic screening, diagnostic, and treatment (EPSDT) program. DHCF contracts with Qlarant to serve as the External Quality Review Organization (EQRO). On October 1, 2020, Qlarant began performing an annual medical record review of completed preventive services in accordance with the **District's HealthCheck Periodicity Schedule** for children up to the age of 20.

MCOs are assessed using five components including: Health and Developmental History; Comprehensive Physical Examination; Laboratory Tests/At-Risk Screenings; Immunizations; and Health Education/Anticipatory Guidance. A minimum performance score of 80% is required for each component.

Additionally, EPSDT certified providers are required to follow guidance from the District of Columbia Department of Health Immunization Schedule, as well as age-specific EPSDT developmental forms and preventive screen questionnaires. EPSDT certified providers are strongly encouraged to use the **District of Columbia Immunization Information System (DOCIIS)** website for tracking and updating immunizations and to follow up with lab results and referrals. We recommend providers include complete medical record documentation in order to support rendered EPSDT services.

DHCF makes helpful forms available for use by providers on their website at **DCHealthCheck.net/trainings/documentation/epsdt/index.html**. If you are unable to print a copy of any of the EPSDT forms, call us at **855-798-4244** (select option 2 for Provider and then option 2 for Provider Relations), and a copy will be provided to you.



Case Management services and other available benefits

Case Management Services are provided by licensed registered nurses and social workers, and coordinators. These professionals assist enrollees in the management of their biopsychosocial needs. This is done telephonically and face to face by educating the enrollee on disease self-management, facilitating access to health care, and connecting the enrollee to needed resources within the community. Case managers work closely with providers to ensure that their enrollees receive appropriate and timely health care.

Case Management services

We provide Case Management services to our most complex and highest risk enrollees, as well as those requiring care coordination and resource management.

Enrollees identified by District of Columbia Health Care Finance (DHCF) as 'Special Needs Population' include an adult age 21 or older who:

- Has a chronic, physical, developmental or behavioral health condition;
- Receives SSI;
- Has a disability that meets the DDI definition.

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Inclusion criteria for adult enrollees include, but is not limited to:

- High Risk Pregnancy
- Diabetes
- Asthma
- COPD
- Hypertension
- Cardiovascular Disease
- HIV
- Substance Use Disorder
- Social Issues/Mental Health

Inclusion criteria for pediatric enrollees include but is not limited to:

- Diabetes
- Asthma
- Obesity
- Epilepsy
- Chronic Lung Disease
- Cardiovascular Disease (CAD)
- Attention Deficit Hyperactivity Disorder (ADHD)
- Depression
- Anxiety
- Substance Use Disorder
- Other Mood Disorder

Transition Care Case Management services

Transition Care Case Management is a service provided by MedStar Family Choice District of Columbia to assist your patient, identified as high risk for readmission when transitioning from the hospital to home. This service is provided by registered nurse case managers who work closely with your patient to assist with adherence to the discharge plan ordered by the hospital care team, locating providers, scheduling follow-up appointments, and assisting with transportation if needed. This service is offered for 30 days, and if after that time your patient requires further assistance, they will be referred to one of our other case management services.

Enrollment

Enrollee participation in Case Management services is voluntary and enrollees can start, stop, or decline participation at any time. However, they are automatically included in the programs once identified by us as meeting qualifying criteria. Adults with special healthcare needs as defined by DHCF are mandated to be in some level of perpetual Case Management.

To refer your enrollee to any of the above services, please fax your referral to 202-243-6253, or call us at **855-798-4244** (select option 2 for Provider and then option 1 for Care Manager). We are available Monday through Friday from 8 a.m. to 5:30 p.m. Any faxes or voice messages received after hours will be handled the next business day.

Additional enrollee benefits

Resource connection

A case manager can connect your patients with resources in their community to assist them with mental and/or substance use needs, utility turn-offs, food assistance, and emergency shelters. Printed educational materials with information on chronic conditions are available for enrollees. The information is written in easy to understand language. A case manager is available to answer your patient's questions and concerns, and to advise on wellness incentives that may be available to them.

Coordinate care

A case manager can assist your patient with locating a specialist in their area, as well as scheduling appointments and coordinating transportation based on your patient's needs. For more information, call **855-798-4244** (select option 2 for Provider and then option 1 for Care Manager).

How to refer enrollees to specialists

Referrals to an in-network provider

Primary care providers (PCP) should use the Uniform Consultation Referral Form to refer enrollees to a specialist. Other referral forms generated by a provider's electronic medical record system are accepted as long as all information that is on the Uniform Consultation Referral Form is represented on the referral form that the PCP is generating. If a referral is requested by a specialist on the day of an enrollee's visit and the referral is not ready, or if the enrollee presents to the specialist office without a copy of the referral that was provided to them, PCPs may give the specialist verbal consent to see that patient on the date of service. Verbal consent will permit the enrollee's treatment while the referral is completed by the PCP. The specialist should not turn the enrollee away, as the referral is not required to be submitted with the claim. If the specialist does not obtain verbal approval from the PCP, then the specialist can see the enrollee one time without the referral. The office notes should then be sent to the PCP for the enrollee's chart.

Referrals from specialists

Specialists can refer to other specialists if they receive written or verbal approval from the PCP (follow the documentation steps outlined above). Providers should use the Uniform Consultation Referral Form to refer enrollees to a specialist. Other referral forms generated by a provider's electronic medical record (EMR) system are accepted as long as all information that is on the Uniform Consultation Referral Form is represented on the referral form that the specialist is generating. If a referral is requested

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by a specialist on the day of an enrollee's visit and the referral is not ready, the referring provider may give the specialist a verbal consent to see that patient on the date of service. Verbal consent will permit the enrollee's treatment while the referral is being completed by the referring provider. Document the verbal approval in the patient's medical chart.

If the specialist does not obtain verbal approval from a referring provider or PCP, then the specialist can see the enrollee one time without the referral. The office notes should then be sent to the PCP for the enrollee's chart.

Referrals for lab and radiology services

PCPs and specialists are to directly refer their MedStar Family Choice District of Columbia (MFC-DC) patients for lab and radiology services to in-network freestanding locations and facilities. Specialists should not send their enrollees back to the PCP for a referral. All providers should use a Lab Requisition form for labs, and providers can either use a Uniform Consultation Referral Form and/or their electronic medical record referral form or write a script for radiology requests.

Referrals to physical therapy, occupational therapy, and speech therapy

Both PCPs and specialists can refer to outpatient physical therapy, occupational therapy, and speech therapy. Prior authorization is required for more than 30 visits per injury, per service. Please note: physical therapy services provided by a chiropractor are not covered and must be directed to an in-network physical therapy provider. All providers are encouraged to use the "Find A Provider" feature on our website (**MedStarFamilyChoiceDC.com**) in order to receive assistance in finding in-network specialists, laboratories, and radiology providers. Please note, all referrals to out-of-network providers require a prior authorization.

Please send all questions regarding referrals to MFC-DC Provider Relations at **mfcdc-providerrelations@medstar.net** or **855-798-4244 (select option 2 for Provider and then option 2 for Provider Relations).**

How to request a second opinion for an enrollee

On occasion, MedStar Family Choice District of Columbia (MFC-DC) enrollees may request to seek a second medical opinion. Enrollees have the right to do so and should be referred to a different in-network provider by his/her primary care physician (PCP).

If an in-network provider is not available to offer a second opinion, an out-of-network provider can be requested. The enrollee's PCP should work with the enrollee, as well as the MFC-DC Utilization Management (UM) department, when a second opinion must be scheduled with an out-of-network provider. A referral from the enrollee's PCP, along with a prior authorization from the UM department, before the enrollee's appointment with the non-participating physician, is required. Prior authorization can be obtained by faxing a Uniform Consultation Referral form or the Prior Authorization (Non-Pharmacy) Request form to us at 202-243-6258 or by calling **855-798-4244**, (select option 2 for Provider and then option 2 for Provider Relations). These forms can be found on our website at **MedStarFamilyChoiceDC.com/providers/utilization-management**.

How Utilization Management authorization review works

To ensure enrollees receive proper health care, we follow a basic prior-authorization process. To request prior-authorization, all appropriate ICD-10/CPT/HCPCS and supporting clinical information must be included with the provider's request. Requests for referrals or authorization can be included on our Uniform Consultation Referral Form or the applicable Prior Authorization (Pharmacy, Non-Pharmacy, Pain Management, DME) Request Form respectively. Clinical information must be submitted with the request. Our experienced clinical staff reviews all requests, and prior-authorization decisions are based on nationally-recognized criteria, such as Inter-Qual and Medicare guidelines. Additional authorization criteria can be found at **MedStarFamilyChoiceDC.com** in our Utilization Management (UM) criteria policy.

Enrollee needs that fall outside of standard criteria are reviewed by our medical directors for plan coverage and medical necessity. We do not reward practitioners or other individuals for issuing denials of coverage of care. UM decision making is based only on appropriateness of care and services and existence of coverage. In addition, there are no financial incentives for UM decision makers that would encourage decisions that result in underutilization. Providers may request a written copy of the criteria used in the decision making process by contacting us at **855-798-4244** (select option 2 for Provider and then option 1 for Authorizations), Monday through Friday, from 8 a.m. to 5:30 p.m. Authorization requests should be made no less than five to seven business days in advance of the service.

Please allow up to 14 days for us to process a complete authorization request. Requests are considered complete when all necessary clinical information has been received from the provider. The final decision is made within 14 calendar days from the initial request for authorization, whether or not all clinical information has been received. For enrollees with urgent authorization needs, providers and/or staff should contact us at **855-798-4244** (select option 2 for Provider and then option 1 for Authorizations/Care Manager). If we deny the prior authorization request, the provider and enrollee will receive a written copy of the denial and its rationale. In addition, the denial letter will indicate that the treating provider may contact the medical director who made the decision to discuss the case by calling **855-798-4244** (select option 2 for Provider and then option 1 for Authorizations/Care Manager).

Understand PCP auto assignment and verify enrollee eligibility

Enrollees who fail to designate a primary care provider (PCP) after enrolling in MedStar Family Choice District of Columbia (MFC-DC) will be automatically assigned to a PCP that is geographically close to the enrollee's residence. Enrollees under the age of 21 are automatically assigned to early and periodic screening, diagnostic, and treatment (EPSDT) providers, as appropriate. Enrollees may change PCPs at any time by calling Enrollee Services. If your name is not listed on the enrollee's ID card on the date of service, you are permitted to see the enrollee as long as you are participating with MFC-DC and the enrollee is eligible with MFC-DC on the date of service. MFC-DC does not deny claims when an enrollee presents an ID card that does not reflect your office as the PCP. This is to prevent participating PCP offices from turning enrollees away when they are active on the date of service. PLEASE DO NOT TURN ENROLLEES AWAY!

Changing a PCP is relatively simple. When possible, we ask that your office assist the enrollee with having their enrollee ID card changed to reflect the correct PCP. Please follow these instructions if your office is not printed on the card as the enrollee's PCP:

- Always verify through IVR that the enrollee is an eligible MFC-DC enrollee on the date of service by calling **202-906-8319** (inside DC Metro area) or **866-752-9233** (outside DC Metro area).
- See the patient if they are active. Do not reschedule the appointment.
- Ask the enrollee to call Enrollee Services at **888-404-3549** to request a new enrollee card reflecting their correct PCP name prior to the next scheduled appointment. You may allow the patient to call from your office while they are waiting to be seen. (You can also utilize the Provider Data Web Portal at **ProviderPortal.MedStarFamilyChoice.com** to make changes.)
- Follow current authorization procedures, if applicable. A list of services requiring prior authorization is available at **MedStarFamilyChoiceDC.com** or can be obtained by calling Provider Relations.

Please keep in mind the importance of current PCP information in regards to enrollee ID cards. This information is used to create enrollee rosters that are mailed monthly to PCP offices. These rosters are used by MFC-DC to send enrollee information to provider offices and for enrollee outreach. If the roster is inaccurate, the PCP on file may receive mailed information that needs to be included in a chart or phone calls with information for an enrollee who is no longer under their care.

If you need further assistance regarding the enrollee's benefits and eligibility, call Enrollee Services at **888-404-3549** (Select Option 2 for DC plans and then Option 2 for Provider Services).

Our website has been redesigned and updated

The new direct MedStar Family Choice District of Columbia (MFC-DC) website link is **MedStarFamilyChoiceDC.com**. If you go to **MedStarFamilyChoice.com**, you'll arrive at a landing page where you can choose between the Maryland or District plans.

From the **MedStarFamilyChoiceDC.com** home page, providers will select "For Providers" from the top navigation. The content in this new website is organized similar to the old website. The Provider homepage features the following sections:

- Make Provider Changes
- Provider Resources
- Claims, Appeals, and Grievances
- Clinical Practice Guidelines
- Pharmacy and Formulary
- Preauthorization and Utilization Management
- Become a Credentialed Provider
- Provider Manual
- Refer Patient to a Specialist
- Quality Monitoring Programs

In addition, the new website has menus on the right side of each page as well as a redesigned header and footer. The MFC-DC provider website is updated regularly. Providers will find the following information:

- Appeal Process
- Availability of UM Criteria
- Case Management and Disease Management Services
- Change Requests or Demographic Updates
- Claims Information (including a link to the Online Claims Status Check)
- Clinical Practice Guidelines
- Contact Information for Medstar Family Choice District of Columbia
- Credentialing Process and Recredentialing Process
- Find-A-Provider (searchable provider directory)
- Formulary
- Hours of Operation and After-Hours Instructions
- Interpreter Services
- Notice of Privacy Practices
- Outreach Program
- Pharmacy Protocols and Procedures
- Pre-Authorization Requirements
- Provider Alerts
- Provider Manual
- Provider Newsletters
- Quality Improvement Programs
- Quick Reference Guide
- Utilization Management Decision Making

If your office has any issues or questions regarding the website or would like any materials in a printed format, please contact the MFC-DC Provider Relations at **mfcdc-providerrelations@medstar.net** or **855-798-4244** (select option 2 for Provider and then option 2 for Provider Relations).

Find all MedStar Family Choice District of Columbia provider contacts here!

Each participating MedStar Family Choice District of Columbia (MFC-DC) provider is assigned a Provider Relations associate to assist with questions regarding the MFC-DC health plans.

If you are not certain who your Provider Relations associate is, please call or email MFC-DC Provider Relations, and we can assist you. You can also click this link to access the **Provider Relations Associate Territory Assignment** information on our website.

Provider Relations *Provider Orientation/Targeted Education, Site Evaluations for New Locations, Demographic Changes, Provider Terminations, Assistance with non-claim related Provider questions/concerns, Provider Contracting*	**855-798-4244** (select option 2 for Provider and then option 2 for Provider Relations) **mfcdc-providerrelations@medstar.net**
Credentialing Status Checks	**msfc.credentialing@medstar.net**
Outreach Department *Newborn Coordination, Enrollee Compliance*	**800-905-1722**, option 1 888-991-2232 (fax)
Care Management *Pharmacy, inpatient and outpatient authorization (including medical vision)*	**800-905-1722** 888-243-1790 (fax)
Claims *Claims Status, Eligibility Verification, Enrollee Benefits, PCP Assignment*	**Provider Claims Portal** **MedStarFamilyChoiceProfessionalPWP.WonderboxSystem.com/PWP/Landing** If you need assistance accessing the portal, please call **844-275-8756**. **MedStar Family Choice Claims Processing Center** PO Box 2189 Milwaukee, WI 53201 **800-261-3371** **Eligibility Verification** **202-906-8319** (inside DC Metro area) **866-752-9233** (outside DC Metro area) **EFT Assistance** **medstarEFT@skygenusa.com**
Behavioral Health/Substance Abuse	**800-777-5327** (Magellan)
Dental	**844-391-6678** (Avesis)
Routine Vision	**844-391-6678** (Avesis)

You may contact MFC-DC, Monday through Friday, between 8 a.m. and 5:30 p.m. Providers have the option to leave a message or send a fax after normal business hours. However, any calls and faxes received after hours will be addressed the next business day.

MedStar Family Choice

DISTRICT OF COLUMBIA

ACCREDITED NCQA HEALTH PLAN INTERIM

ACCREDITED NCQA CASE MANAGEMENT 3 YEARS

If you have questions regarding information in this newsletter, please call us, Monday through Friday, 8 a.m. to 5:30 p.m., at **855-798-4244** (select option 2 for Provider and then option 2 for Provider Relations). You can also email us at **mfcdc-providerrelations@medstar.net**.

This Provider Newsletter is a publication of MedStar Family Choice District of Columbia. Submit new topics for subsequent publication consideration to **mfcdc-providerrelations@medstar.net**.

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It's how we treat people.