

<b>V. PRIMARY CARE PROVIDERS (PCP) / PRIMARY CARE OBSTETRICIANS (PCO)</b>	
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## **5.1 PCP'S RESPONSIBILITIES**

Missouri Care Primary Care Providers' (PCPs) responsibilities include but are not limited to:

1. Provide or arrange for urgent covered services as defined in the PCP contract, including emergency medical services, to members on a twenty-four (24) hour per day, seven (7) days per week basis.
2. Verify the enrollment and PCP assignment of the member on the day of, but prior to the provision of covered services. The PCP should utilize the Interactive Voice Response (IVR) system, operated by the Missouri Division of Medical Services. Failure to verify member enrollment and PCP assignment may result in claim denial.
3. Provide to Members:
  - a) Office visits during regular office hours which shall not be less than twenty (20) hours per week and not less than three (3) days per week for individual practitioner; or not less than thirty five (35) hours per week for group practices or institutional Providers; and
  - b) Office visits or other services during non-office hours as determined to be medically necessary; and
  - c) Response to phone calls within a reasonable time on a twenty-four (24) hour per day, seven (7) days per week basis.

4. Agree to ensure a member's waiting time in the PCP office shall not exceed sixty (60) minutes, unless the member is late and/or the PCP is unavailable due to an emergency.
5. Coordinate the provision of covered services to members by:
  - a) Counseling members and their families regarding member's medical care needs;
  - b) Initiating referrals of members for specific covered services to participating specialty health care Providers;
  - c) Monitoring progress of members' care and managing utilization of specialty services to facilitate the return of member's care to PCP as soon as medically appropriate.
6. Maintain staff membership and admission privileges in good standing at one of Missouri Care's contracted hospitals unless otherwise specifically authorized by Missouri Care.
7. Use only Missouri Care contracted hospitals or appropriately licensed medical facilities for the admission of members. Otherwise prior authorization must be obtained from Missouri Care. In the case of an emergency where use of a contracted hospital or other facility is not feasible for medical reasons, a prior authorization is not required. PCP will provide covered services to members while in a hospital, nursing home, or other health-care facility as determined to be Medically Necessary by the PCP or Medical Director.
8. Maintain a current DEA and BNDD number throughout the term of his/her contract with Missouri Care and complying with all applicable controlled substance regulations. Missouri Care encourages the PCP to record the DEA and BNDD numbers on all prescriptions.
9. Must be state licensed and have training and experience in his/her respective field(s) of practice, may be board certified, have completed an approved training program, or be generally recognized by the provider community as being skilled in his/her respective practice.
10. Provide preventive health services in accordance with the MC+ Program rules and Missouri Care medical policies. The preventive health services shall include but not be limited to:
  - a) Periodic health assessments for all assigned members twenty-one (21) years of age and older that include major medical, social, and family history within a two (2) year time frame.
  - b) Immunizations and other measures for the prevention and detection of disease, including instruction in personal health care measures and information on proper and timely use of appropriate medical resources

pursuant to Missouri Care medical policy. Immunizations follow the most recent immunization recommendations designated by the State Agency. (See Attachment V.B for Vaccines For Children information)

- c) Tuberculosis screening, including the use of Mantoux PPD skin test. tuberculosis screening shall be in accordance with current Centers for Disease Control/American Thoracic Society Guidelines: treatment of tuberculosis and tuberculosis infection in adults and children, or their equivalent.
- d) Childhood lead poisoning prevention services including verbal lead assessments beginning at age six (6) months and continuing through age seventy-two (72) months. Lead screening shall follow guidelines of the Health Care Financing Administration in effect for the specific time period and Centers for Disease Control guidelines: Screening Young Children for Lead Poisoning.
  - i. Blood level testing is mandatory at twelve (12) and twenty- four (24) months and when indicated from the lead screening assessment.
  - ii. Upon identification of a member having a blood lead level greater than ten (10) µg/dl, the PCP will refer the member to Missouri Care for lead case management services.
  - iii. The State of Missouri has developed a mandatory HCY Lead Screening Guide. The form must be signed and dated by the screener and retained in the medical record. The State of Missouri supplies the tools at no cost to the provider. The forms can be ordered by calling Medicaid Provider Services at 573-751-2896 or by accessing the Division of Medical Services web site at [www.dss.state.mo.us/dms](http://www.dss.state.mo.us/dms).

For questions regarding childhood lead poisoning prevention and treatment, please contact Missouri Care Health Plan at 1-800-322-6027 or the Department of Health and Senior Services at 573-526-4911.

- e) Early Periodic Screening Diagnosis and Treatment also known as healthy children and youth (EPSDT and HCY) for all assigned members up to the age of twenty-one (21) years. The PCP is required to keep immunizations and screenings current according to the EPSDT periodicity schedule. Missouri Care Health Plan strongly recommends annual exams for all children over the age of two. Missouri Care Primary Care Physicians are required to:

- i Assume responsibility for the provision and documentation of EPSDT screening service for all assigned members under the age of twenty-one (21) years in accordance with the MC+ Program EPSDT periodicity schedule (see schedule below). The State of Missouri follows the American Academy of Pediatrics schedule for preventive pediatric health care as a minimum standard for screening frequency.
- ii In addition, children receiving ongoing therapy must have a current EPSDT screen in order for continuation of services to be authorized.

**EPSDT Periodicity Schedule**

Newborn (2-3 days)	4-5 months	12-14 months	24 months	5 years	10-11 years	16-17 years
By one month	6-8 months	15-17 months	3 years	6-7 years	12-13 years	18-19 years
2-3 months	9-11 months	18-23 months	4 years	8-9 years	14-15 years	20 years

**COMPONENTS OF A FULL SCREENING**

- Interval History
- Unclothed Physical Exam
- Anticipatory Guidance
- Lab/Immunizations (when indicated)
- Lead Assessment and Testing
- Developmental Screening
- Fine Motor/ Gross Motor Skills
- Hearing
- Vision
- Dental

- iii Use the standardized EPSDT tracking forms. The Healthy Children and Youth [HCY Screening] and the HCY Lead Risk Assessment Guide are both mandatory screening tools. Both forms must be signed and dated by the screener and retained in the medical record. The State of Missouri supplies the tools at no cost to the provider. The forms can be ordered by calling Medicaid Provider Services at 573-751-2896 or by accessing the Division of Medical Services web site at [www.dss.state.mo.us/dms](http://www.dss.state.mo.us/dms).
- iv Refer members under age twenty-one (21) years as necessary for follow-up, diagnosis and treatment, ensuring

that treatment is initiated within sixty (60) days of screening services.

- v Have an adequately equipped office with equipment and supplies necessary to provide EPSDT services.
  - vi Utilize clinical encounters to address EPSDT services to avoid missed opportunities and assess the immunization status of all children during each encounter.
  - vii Report all EPSDT encounters on the required claim form using correct CPT/EPSDT codes.
  - viii Abide by the Missouri Care pediatric and minimum medical record standards and practice according to the standards for pediatric immunization practices.
  - ix Participate in an annual review to assure compliance with Missouri Care medical record standards, pediatric standards and EPSDT program services, which includes chart reviews.
11. Prescribe or authorize the substitution of generic pharmaceuticals when appropriate and agreeing to abide by the Missouri Care preferred products list.
  12. Maintain and be covered in full force and effect at all times by professional liability insurance as well as the other insurance requirements.
  13. Agree to adhere to Missouri Care's managed care philosophy and principles, and encouraged to participate as active members on Missouri Care's standing committees.
  14. Agree to utilize current coding guidelines including CPT, HCPCS and State required regional CPT/HCPCS codes, if any.
  15. Agree to adhere to practice guidelines consistent with those contained within Missouri Care's Health and Wellness Policies.
  16. Comply with federal regulations of the Occupational Safety and Health Administration including, without limitations, the regulations concerning Bloodborne Pathogens Standards at 29 C.F.R. Part 1910.1030, which became effective January 1, 1992.

17. Conduct an appropriate substance abuse screening as part of each member's initial appointment or baseline physical and at future appointments if indicated by the member's behavior. Agree to (A) offer a more detailed screening/assessment to members identified as being at risk for substance abuse; (B) identify the most appropriate level of care for the member, using standardized placement criteria; (C) inform the member of comprehensive substance abuse treatment and rehabilitation (C-STAR) programs and/or contracted certified substance abuse treatment providers.
18. Agree to follow all of Missouri Care's policies and procedures, including Quality Management and Utilization Management.
19. Refer eligible members to the Women, Infants and Children (WIC) Supplemental Food Program. (See Attachment V.B for program eligibility and referral criteria.)
20. Render services to members who are diagnosed as having human immunodeficiency virus (HIV) in the same manner and to the same extent as other members and under the compensation terms set forth in the Missouri Care contract.
21. Upon diagnosis or identification of a member with HIV, the PCP will offer a referral to the specialized case management programs. If the member refuses, the PCP will continue to provide case management services. The member may request, and be granted a referral to case management services at any time following his/her diagnosis.
22. Agree to refer members to participating hospital emergency rooms for emergent care only. PCP shall make a concerted effort to educate and instruct members about the proper utilization of the PCP office in lieu of hospital emergency rooms.
23. Abide by the Missouri Care Referral and Prior Authorization policies found in Chapters VIII and IX of this Manual.
24. Use Missouri Care contracted hospital(s), specialists, ancillary Providers and other health care professionals.
25. Obtain authorization for all hospital admissions, and all outpatient surgeries and related medical procedures.
26. Report all services provided to Missouri Care members in an accurate and timely manner.

27. Identify and bill other third-party carriers or insurers first. Missouri Care has a third party liability unit that will assist in verifying primary insurance. A provider relations representative can assist Providers in contacting the TPL unit.
28. Continue to provide services to a member transitioning to another Provider and/or health plan until such time that member is safely transferred; cooperating with the receiving Provider and/or health plan in transferring relevant records.
29. Perform and bill only for those lab tests for which provider is CLIA certified to perform in the office.

## **5.2 PCP APPOINTMENT GUIDELINES AND OFFICE WAIT TIMES**

PCPs are responsible for providing to members (a) office visits during regular office hours which shall not be less than twenty (20) hours per week and not less than three (3) days per week for individual practitioners, or not less than thirty-five (35) hours per week for group practices or institutional providers, unless otherwise specifically authorized by Missouri Care; and (b) office visits, home visits or other appropriate visits during non-office hours as determined Medically Necessary, and (c) response to phone calls within a reasonable time on a twenty-four (24) hours a day, seven (7) days per week. PCPs should schedule or arrange time-specific appointments and referral appointments for members such that the request-to-appointment time meets the following guidelines:

1. If necessary, new members initial routine appointment within thirty (30) days of the date of their enrollment. For those members who are children under the age of two (2) years old needing EPSDT screening services, appointments will be in accordance with the EPSDT periodicity schedule.
2. Well child assessments within thirty (30) days of request.
3. Initial prenatal or postpartum visits within seven (7) days of member's request during the first two (2) trimesters or within three (3) days during the third trimester. High-risk pregnancies within three (3) calendar days of identification of high risk, or immediately if an emergency exists.
4. Family planning visits within ten (10) days of request.
5. Urgent care appointments for illness injuries that require care immediately but do not constitute emergencies, within 24 hours (e.g. high temperature, persistent vomiting or diarrhea symptoms which are of sudden or sever onset but which do not require emergency room services).

6. Routine care, with symptoms, appointment must be available within one (1) week or five (5) business days whichever is earlier (e.g. persistent rash, recurring high grade temperature, nonspecific pain, fever).
7. Routine care, without symptoms, appointments must be available within thirty (30) calendar days (e.g. well child exams, routine physical exams).
8. For mental health and substance abuse services, aftercare appointments shall occur within one (1) week or five (5) business days after hospital discharge whichever is earlier.
9. If a member is pregnant or diagnosed with HIV and is identified as a substance abuser, the PCP will refer the member for substance abuse treatment within twenty-four (24) hours of the member's request or identification.
10. Initial newborn EPSDT screen shall occur in the hospital following delivery. Two (2) home visits will be offered when a mother and a newborn are discharged early (the standard is currently set at a forty-eight (48) hour inpatient stay for a normal vaginal delivery and a ninety-six (96) hour stay for a cesarean section delivery). The initial visit will occur within twenty-four (24) to forty-eight (48) hours of discharge, in the home, by participating home health provider or local public health agency.
11. ER visit follow-up, if required, within seventy-two (72) hours.
12. Well child assessments for all the children in a family, enrolled with the PCP, within fifteen (15) business days of the request, when the PCP is notified that the family has been sanctioned by the State for failure to secure services within a timely manner.
13. For a child between the ages of two (2) and twenty-one (21) with a diagnosed condition requiring follow-up, the PCP shall contact the member or parent/guardian to reschedule appointments within thirty (30) days of a missed appointment for the first two (2) missed appointments and within sixty (60) days of any additional rescheduled appointments thereafter.
14. A member's waiting time at the PCP's office shall not exceed sixty (60) minutes, unless the member is late and/or the PCP is unavailable due to an emergency.

### **PRIMARY CARE OBSTETRICIAN (PCO)**

### **5.3 PCO's RESPONSIBILITIES**

The member's PCP will refer a pregnant member to a Primary Care Obstetrician (PCO) immediately after the pregnancy is confirmed or the member may self refer to the PCO of their choice within the Missouri Care network. A PCO is a physician, certified nurse midwife (CNM) or a nurse practitioner licensed to practice in the field of obstetrics/gynecology who assumes primary responsibility for supervising, coordinating and providing initial and primary care to pregnant members. The CNM or nurse practitioner must have a collaborative practice agreement with a participating Missouri Care obstetrician/gynecologist. PCOs coordinate a member's care until sixty (60) days after delivery or termination of pregnancy, at which time the member is assigned back to the member's PCP or until the member loses eligibility.

Missouri Care requires PCOs to follow the standard for prenatal care set by The American College of Obstetricians and Gynecologists (ACOG).

Missouri Care Primary Care Obstetricians (PCOs) responsibilities include but are not limited to:

1. Verify the enrollment and assignment of the member prior to the provision of covered services. This is done through the State Interactive Voice Response (IVR) System. Failure to verify member enrollment and assignment may result in claim denial.
2. Provide or arrange for covered services to members as defined herein, including Emergency Medical Services, on a twenty-four (24) hour per day, seven (7) days per week basis.
3. The PCO must notify Missouri Care of all members receiving prenatal care by completing the Pregnancy Risk Screening and Notification form and faxing within 2 days of initial visit to Missouri Care. Once the Pregnancy Risk Screening Form is received, a global authorization number is issued and faxed back to the PCO. The Pregnancy Risk Screening Form serves as an authorization for global ob services and is required for reimbursement.
4. Provide to Members:
  - a) Office visits during regular office hours which shall not be less than twenty (20) hours per week and not less than three (3) days per week for individual practitioners, or thirty-five (35) hours per week for group practices or institutional providers; and
  - b) Office visits or other appropriate visits during non-office hours as determined Medically Necessary; and

- c) Response to phone calls within a reasonable time on a twenty-four (24) hour per day basis, seven (7) days per week.
  - d) Ensure that a member's waiting time shall not exceed sixty (60) minutes unless the member is late and/or the PCO is unavailable due to an emergency.
5. Coordinate the provision of Covered Services to members by:
  - a) Counseling members and their families regarding member's medical care needs including family practice and advance directives;
  - b) Initiating referrals of member for specific Covered Services to participating health professionals, hospitals and Providers;
  - c) Monitoring progress of member's care and coordinating utilization of services to facilitate the return of member's care to their PCP sixty (60) days after delivery.
6. Maintain active staff membership and admission privileges in good standing with one of the hospitals that Missouri Care has contracted as a participating hospital unless specifically authorized by Missouri Care.
7. Admit members in need of hospitalization only to participating hospitals unless:
  - a) Prior authorization for admission to some other facility has been obtained from Missouri Care or
  - b) The member's condition is emergent and use of a participating hospital or other contracted facility is not feasible for medical reasons.
  - c) With respect to a pregnant woman who is having contractions, that there is inadequate time to effect a safe transfer to another hospital before delivery; or that transfer may pose a threat to the health or safety of the woman or the unborn child.
8. Agree to provide medically necessary covered services to members while in a hospital or other appropriate contracted facility and provide or arrange appropriate postpartum care in compliance with Chapter 197 RSMo.
9. Maintain current DEA and BNDD registration throughout the term of their Agreement. Missouri Care encourages PCOs to record their DEA and BNDD numbers on all prescriptions.
10. Must be licensed and have training and experience in obstetrics/gynecology, may be board certified in obstetrics/gynecology, have completed an approved training program, or be generally recognized by the provider community as being skilled in obstetrical/gynecological practice.
11. Prescribe and authorize the substitution of generic pharmaceuticals and agreeing to abide with the Missouri Care preferred drug list.

12. Agree to render services to members who are diagnosed with human immunodeficiency virus (HIV) in the same manner and to the same extent as other members and under the compensation terms set forth herein.
13. Upon diagnosis or identification of a member with HIV, the PCO will offer a referral to a specialized case management program. If the member refuses, the PCO will continue to provide case management services. The member may request and be granted a referral to case management services at any time following his/her diagnosis.
14. Not refer or direct members to any, (including participating) hospital emergency rooms for non-emergent medical services at any time during the term of the Agreement. PCO's should make a concerted effort to educate and instruct members about the proper utilization of the PCO office in lieu of hospital emergency rooms.
15. Compensate any Provider, who upon request of the PCO, provides Covered Services that are included under the OB global package rate. Financial reimbursement to any Provider who upon request of the PCO provides Covered Services that are included under the OB global package rate shall be a matter decided between the two (2) Providers involved. Missouri Care shall not be responsible for payment to the covering Provider.
16. Maintain responsibility for care until the first of the month following sixty (60) days after delivery with a minimum of one (1) postpartum visit at approximately six (6) weeks postpartum or within seven (7) days of request.
17. Comply with federal regulations of the Occupational Safety and Health Administration including, with limitation, the regulations concerning Bloodborne Pathogens Standards at 29 C.F.R. Part 1910.1030.
18. Conduct an appropriate substance abuse screening as part of each member's initial appointment or baseline physical and at future appointments if indicated by the member's behavior. Agreeing to (A) offer a more detailed screening/assessment to members identified as being at risk for substance abuse; (B) identify the most appropriate level of care for the member, using standardized placement criteria; (C) inform the member of comprehensive substance abuse treatment and rehabilitation (C-STAR) programs and/or contracted certified substance abuse treatment providers.
19. Maintain in full force and effect and be covered at all times during the term of the Agreement by professional liability insurance as well as any other insurance requirements.

20. Agree to adhere to Missouri Care's managed care philosophy and principles, and is encouraged to participate as an active member on Missouri Care standing committees.
21. Agree to adhere to Missouri Care's quality management and utilization management policies and procedures.
22. Agree to utilize current coding guidelines including CPT, HCPCS and State required regional CPT/HCPCS codes, if any.
23. Provide preventive health service in accordance with MC+ rules and regulations and Missouri Care medical policies. The preventive health services include but are not limited to:
  - a) Periodic health assessments for all assigned members twenty-one (21) years of age and over that includes major medical, social and family history within a two (2) year time frame.
  - b) Immunizations and tuberculosis screening, and other measures for the prevention and detection of disease, including instruction in personal health care measures and information on proper and timely use of appropriate medical resources pursuant to Missouri Care medical policy provided by or through Missouri Care. Immunizations are recommended in accordance with the Advisory Committee of Immunization Practice (ACIP) guidelines and a separate schedule for hepatitis B immunizations of adolescents. (See Attachment V.A for Vaccine For Children information)
  - c) Early Periodic Screening Diagnosis and Treatment, also known as Healthy Children and Youth, (EPSDT or HCY) for all assigned members up to the age of twenty-one (21) years in accordance with the EPSDT periodicity schedule, and includes tracking forms and specific behavioral health services for certain eligible members. PCO is required to keep immunizations and screening current according to schedules specified by the State (see section 5.1.10E).
24. Upon identification of a member having a blood lead level greater than fifteen (15) µg/dl, the PCO will refer the member to Missouri Care for lead case management services.
25. Refer eligible members to the WIC program. As part of the case management process for postpartum hospitalized mothers, Missouri Care providers will coordinate the members' access to external resources, such as the WIC program. (See Attachment V.B for program eligibility and referral criteria)

PCO shall report such referral within two (2) working days to the Missouri Care Prenatal Case Management.

26. Identify and bill other third-party carriers or insurers first. Missouri Care is the payer of last resort.
27. Continue to provide services to a member transitioning to another Provider and/or health plan until such time that member is safely transferred; cooperating with the receiving Provider and/or health plan in transferring relevant records.
28. Home Birth Services: In accordance with the MC+ managed care home birth policy statement, if a member elects a home birth, the member shall be disenrolled from Missouri Care. The disenrolled member shall then receive services through the MC+ fee-for-service program for the home birth.
29. Perform and bill only for those lab tests for which provider is CLIA certified to perform in the office.

#### **5.4 PCO APPOINTMENT GUIDELINES AND OFFICE WAIT TIMES**

The following guidelines apply to PCO Providers: PCOs are responsible for providing to members (a) office visits during regular office hours; and (b) office visits or other appropriate visits during non-office hours as determined Medically Necessary. PCO's should schedule time-specific appointments for members such that the request-to-appointment time meets the following guidelines.

- a) First trimester - within seven (7) days of first request for an appointment or to reschedule a missed appointment
- b) Second Trimester - within seven (7) days of first request for an appointment or to reschedule a missed appointment
- c) Third trimester - within three (3) days of first request for an appointment or to reschedule a missed appointment
- d) High risk prenatal care shall be initiated within three (3) working days of identification or immediately, if an emergency exists
- e) members at high risk shall have a return visit scheduled appropriately to their individual needs.
- f) Follow up to ER visits, if required, within seventy-two (72) hours
- g) Urgent care appointment for illness injuries that require care immediately but do not constitute emergencies, with 24 hours (e.g. high temperature, persistent vomiting or diarrhea symptoms which are

- of sudden or severe onset but which do not require emergency room services).
- h) Routine care, with symptoms, appointments must be available within one (1) week or five (5) business days whichever is earlier (e.g. persistent rash, recurring high grade temperature, nonspecific pain, fever).
  - i) Routine care, without symptoms, appointments must be available within thirty (30) calendar days (e.g. well child exams, routine physical exams).
  - j) PCO shall contact member to reschedule missed appointment within the time frames mentioned above
  - k) Family planning visits within ten (10) days of request.
  - l) For specialty outpatient referral and/or consultation appointments, including behavioral health, consistent with the clinical urgency, no greater than twenty-one (21) days unless otherwise requested by the member.
  - m) If a member is pregnant or diagnosed with HIV and is identified as a substance abuser, the PCP will refer the member for substance abuse treatment within twenty-four (24) hours of the member's request or identification.
  - n) The timing of scheduled follow-up outpatient visits with practitioners will be consistent with the clinical need of the member.
  - o) A member's waiting time at the PCO's office shall not exceed sixty (60) minutes, unless the member is late and/or the PCP is unavailable due to an emergency.
15. Scheduling time-specific office visits during an uncomplicated pregnancy based upon the following recommended standards promulgated by the American College of Obstetrics and Gynecology (ACOG):
- a) Every four (4) weeks for the first twenty-eight (28) weeks of pregnancy;
  - b) Every two (2) - three (3) weeks until thirty-six (36) weeks of gestation; and
  - c) Weekly thereafter.

## **5.5 PCP/PCO OFFICE VISIT CHECKLIST**

When providing services to Missouri Care members, the following steps should be taken:

1. Check the State's Interactive Voice Response (IVR) system to verify enrollment and eligibility. (**NOTE:** Enrollment in and disenrollment from Missouri Care is effective daily)
2. Verify member identity with secondary identification (with photo, if possible.)
3. Secure prior authorization from Missouri Care if appropriate.
4. Refer to Missouri Care contracted specialists unless otherwise authorized by Missouri Care.
5. Under federal law, Missouri Care is the payer of last resort. Identify and bill appropriate third party payer first. (See Section XI)

## **PCP/PCO MEDICAL RECORD REQUIREMENTS**

### **5.6 PCP/PCO MEDICAL RECORDS**

The following standards for medical records have been adopted from the National Committee for Quality Assurance (NCQA) and Medicaid Managed Care Quality Assurance Reform Initiative (QARI) as the minimum acceptable standards within the Missouri Care Primary Care Network.

1. **ORGANIZATION** -- (a) Medical records must be organized systematically and uniformly. (b) Papers must be firmly attached. Individual unit medical records are recommended as opposed to family medical records.
2. **PATIENT IDENTIFICATION** -- Each page in the medical record must contain patient name or patient identification number.
3. **PERSONAL/BIOGRAPHICAL DATA** -- Personal/Biographical data must be noted. This may include address, employer, date of birth, sex, marital status, consent forms, guardianship information, home and work telephone numbers.

4. PROVIDER IDENTIFICATION -- All entries including dictation must be identified by the author and authenticated by his or her entry. Authentication may include signatures or initials thereby verifying that the report is complete and accurate. Medical record notes generated/stored electronically by computer are considered authenticated if there is a demonstrated password protected entry with a time-limited edit capability.
5. ENTRY DATE -- All entries must be dated.
6. LEGIBLE -- The medical record must be legible to someone other than the writer.
7. LISTS:
  - (a) PROBLEM LIST -- Significant illnesses and medical conditions are indicated on the problem list. If the patient has no known medical illness or condition, the medical record must include a flow sheet for health maintenance.
  - (b) MEDICATION LIST -- Current medications are listed.
8. ALLERGIES --
  - (a) Allergies/No known allergies (NKA) must be documented in a uniform location on the medical record.
  - (b) Medication allergies and adverse reactions must be listed if present. List no known allergies (NKA) if applicable.
9. PAST MEDICAL HISTORY (for patients under age twenty-one (21), on first visit // for patients age twenty-one (21) or over, seen three (3) or more times// for obstetrical patients, a risk assessment tool is used) -- Past medical history should be easily identifiable and include serious accidents, operations, illnesses and familial/hereditary disease. For pediatric patients, birth history must be documented.
10.
  - (a) SMOKING/ALCOHOL (for patients seen three (3) or more times) -- Notation concerning cigarettes and alcohol is present.
  - (b) SUBSTANCE USE (for patients seen three (3) or more times) -- Notation concerning recreational/illicit substance use is present.
11. PHYSICAL EXAM (COMPLETE)

- (a) All body systems must be reviewed for patients under age twenty-one (21), at each EPSDT visit // for adults, within two (2) years of the first clinical encounter and every two (2) years thereafter.

HEENT	Lungs	Neck
Heart	Neuro	Back and Extremities

- (b) Height, weight, blood pressure and temperature must be documented on the initial visit.
12. SUBJECTIVE AND OBJECTIVE INFORMATION -- Subjective patient information and objective physical findings are obtained and noted at each visit for the presenting complaints.
13. ASSESSMENT / WORKING DIAGNOSIS -- Working diagnosis is consistent with findings (provider's medical impression).
14. PLAN/TREATMENT -- Documentation of plan of action and treatment are consistent with diagnoses.
15. PATIENT EDUCATION/INSTRUCTIONS -- Documentation is present as applicable for:
- (a) Problems and current diagnosis. In addition, lifestyle management/preventive health information is documented to include, but not be limited to:
- (b) Family planning, sexually transmitted disease education per Missouri Care Family Planning Guidelines (See Section XV).
- (c) Cancer prevention/detection (i.e., sun exposure, breast self-exam, testicular self-exam teaching.)
- (d) Injury prevention -- at least one (1) of the following: Vehicle safety belts, or occupational hazards, or home safety such as smoke alarms.
- (e) Or (for members' birth through twenty (20) years) EPSDT Anticipatory Guidance items as listed on the HCY Tracking Form.
16. CONSULTS/X-RAY/LAB/IMAGING REPORTS/REFERRALS/RECORDS -- (a) Reports are filed in the medical record and initialed by the primary care Provider thereby signifying review. (b) Consultation and abnormal lab imaging study results should have an explicit notation in the medical record of follow-up plans. Referrals, past medical records, hospital records, e.g. operative and pathology reports, admission and discharge summaries, consultations and

ER reports should be filed in the medical record and initialed within sixty (60) days.

17. FOLLOW-UP/RETURN VISITS -- Encounter forms or notes have a notation concerning follow-up care, call or visit. Specific time to return is noted in weeks, months, or as necessary. Unresolved problems from previous visits are addressed in subsequent visits.
18. MEDICAL CARE/SERVICES/CONSULTS -- A general overview of the medical care/services and consults ordered will be reviewed. If any potential quality issues are identified, the reviewer will refer to Missouri Care's designated Medical Director for further direction.
19. IMMUNIZATION RECORD --
  - (a) A separate, distinguishable immunization record is maintained.

- (b) Immunizations are administered per the following recommended schedule or notations are present for exceptions to the schedule:

For all adult members age twenty-one (21) and older, record must indicate patient's immunization status for Td. For all female members of childbearing age, record must indicate blood titer and/or immunization status for rubella.

For members age sixty-five (65) and older, record must indicate immunization status for influenza and pneumococcal.

For all members age twenty-one (21) and over and at high risk, record must indicate immunization status for influenza, pneumococcal and/or hepatitis B.

For members under age twenty-one (21), immunizations are given according to the Centers for Disease Control (CDC) immunization recommendations. There must be a complete immunization record documented. If no record is available, documentation must be present regarding immunization status e.g. "Up To Date" (UTD), stating who reported the status and that a copy was requested for the medical record. Re-immunizations must be considered for all school age children without vaccine records. "Catch-up immunizations" where it is evident that the age-appropriate series lacks full completion of the recommended number of vaccines, must also be considered. Each vaccine in the series must be documented in order for the record of immunization to be complete.

20. PREVENTIVE SERVICES (for adult members seen three (3) or more times) -- Record should indicate preventive services are offered according

to Missouri Care's Adult Screening Guidelines for Asymptomatic Men and Women (See Attachment XV.D).

- (a) Blood pressure every two (2) years
- (b) Pap/breast exam/mammography -- females or testicular exam -- males (per ages on Attachment XV.F)
- (c) Stool for occult blood > fifty (50) years old
- (d) Cholesterol every five (5) years

**OR**

PREVENTIVE SERVICES (for MC+ members under age twenty-one (21)) - Preventive health services must be provided according to the MC+ mandated Early Periodic, Screening, Diagnosis and Treatment (EPSDT) periodicity schedule which is the same as the Healthy Children and Youth (HCY) program.

- (e) EPSDT program <twenty-one (21) years old as documented on the HCY Tracking Form
21. GROWTH CHARTS must be maintained in the medical record until eighteen (18) years of age. Height, weight and head circumference must be plotted on children twelve (12) months and under; height and weight on children over twelve (12) months.

## **5.7 PCP/PCO RECORDS MAINTENANCE AND RETENTION**

Providers, in accordance with Missouri Care and MC+ standards, will maintain records and books relating to the provision of services to Missouri Care members. Specifically:

- (a) Patient records remaining under the care, custody and control of the physician shall be maintained by the physician, or the physician's designee, for a minimum of seven (7) years from the date of when the last professional service was provided.
- (b) Any correction, addition, or change in any patient record made more than forty-eight (48) hours after the final entry is entered in the record and signed by the physician shall be clearly marked and identified as such. The date, time and name of the person making the correction, addition, or change shall be included, as well as the reason for the correction, addition or change.

- (c) A consultative report shall be considered an adequate medical record for a radiologist, pathologist, or a consulting physician.
- (d) When a member changes primary care providers, upon request, his or her medical records or copies of medical records must be forwarded to the new primary care provider within ten (10) business days from receipt of request or prior or prior to the next scheduled appointment to the new primary care provider.

Providers will comply with the State's timeframes for provision of medical records. Providers will make available access to all members' medical records within thirty (30) days should MC+ request any or all of them. Non-expedited requests for records shall be provided within thirty (30) days of request. The Provider will also make medical records available within five (5) calendar days of date received of written request for a single or small volume of records. Immediate access to the records shall be afforded for on-site reviews of records. Emergency requests for medical records will be sent via fax or overnight mail. MC+ is not required to obtain written approval from a member before requesting the member's record from the Provider or other Provider agency.

Upon written request of a member or legal guardian, the Provider shall make a copy without charge of the medical record of the member's health history and treatment rendered.

## **5.8 CONFIDENTIALITY**

All Providers shall treat members' records as confidential and shall comply with all applicable federal and State laws, rules, and regulations governing said records. Confidential information shall be safeguarded pursuant to 42 C.R.F. part 431, Subpart F and 42 C.R.F. part 2, Privacy Standards under HIPPA, and State rules and regulations.

## **5.9 SECOND OPINIONS**

Members have a right to seek a second medical opinion. Certain elective surgical procedures, pursuant to Missouri law, require second opinions prior to surgery. The member may also seek a third medical opinion in the event that the first two (2) opinions are at odds.

## **5.10 ADVANCE DIRECTIVES (PATIENT SELF DETERMINATION ACT)**

The Patient Self-Determination Act of 1990 that became effective December 1, 1991, requires health professionals and facilities serving those covered by Medicare and Medicaid to give adult members written information about the members' right to have an Advance Directive. Advance Directives are written statements either outlining a member's choices for medical treatment or naming a person who should make choices if the member temporarily or permanently loses the ability to make decisions.

Missouri Care's Member Services Department includes information about Advance Directives in the member handbooks sent to new adult members. Providers may be asked questions related to the printed information. If you would like a copy of the Advance Directives information, please contact your Provider Relations Representative.

Missouri Care Providers are required to follow all federal and State Advance Directive policies and procedures.

## **5.11 RELEASE FOR ETHICAL REASONS**

Missouri Care does not require a Provider to perform any treatment or procedure that is contrary to the Provider's conscience, religious beliefs, or ethical principles or policies. Missouri Care does not prohibit a Provider from making a referral to another contracted Provider licensed to provide care appropriate to the member's medical condition.

If a Provider feels he/she has an ethical impediment to performing a covered service or procedure, Missouri Care will make every effort to assist the Provider in referring the member to an alternate Provider. At no time will any Missouri Care Provider or employee suggest, authorize or prescribe an unlawful procedure or service.

## **5.12 NON-DISCRIMINATION**

To ensure mainstreaming of members, Providers certify that Covered Services are provided without regard to race, color, creed, gender, religion, age, national origin, ancestry, marital status, sexual preference, health status, or physical or mental handicap or veteran's status, except where medically indicated; they do not maintain nor provide for their employees any segregated facilities, nor will the Providers perform services at any location where segregated facilities are maintained. Providers will comply with values honoring a member's beliefs,

being sensitive to cultural diversity, and fostering attitudes and interpersonal communication styles that respect each member's cultural diversity.

### **5.13 MARKETING GUIDELINES**

Providers shall not influence a member's enrollment. They are prohibited from the following:

- a. Requiring or encouraging the member to apply for an assistance category not included in MC+ managed care.
- b. Requiring or encouraging the member and/or guardian to use the SSI "opt out" as an option in lieu of delivering health plan benefits
- c. Mailing or faxing health plan enrollment forms
- d. Aiding the member in filling out health plan enrollment forms
- e. Photocopying blank health plan enrollment forms
- f. Distributing blank health plan enrollment forms
- g. Allowing the member to use his/her phone to enroll or change health plans from the Provider's office site.
- h. Participating in three way calls to the MC+ managed care enrollment helpline
- i. Suggesting a member transfer to another health plan
- j. Participating in other activities in which Missouri Care, its representatives, or Providers are engaged in activities to enroll in a particular health plan or in any way assisting a member to enroll in a health plan.

Providers must submit to the State agency, for prior written approval, all materials used to advise members of the health plans with which they have contracts. The following list constitutes approved material:

- A list of all health plans with which the Provider has contracts;
- A letter to previous fee-for-service recipients who may be eligible for MC+ managed care, informing them of all health plan(s) with which the Provider has contracted;
- A display of all contracted health plan logos in an equal fashion;
- A listing of all contracted health plan phone numbers;
- Access to all contracted health plan directories and member handbooks as a member resource but not for distribution; and
- Displaying enrollment helpline phone number.

The Provider shall provide equal representation of all contracted health plans and shall not favor one health plan over another in displayed information.

Providers shall request State agency prepared mandatory MC+ managed care materials from the State agency and will make the general public aware of the MC+ program by providing the following:

- General MC+ eligibility information;
- MC+ applications to complete and mail
- MC+ toll free phone number (888-275-5908).

#### **5.14 FRAUD AND ABUSE**

To report a possible fraud and abuse situation, call the Missouri Care Compliance Program Hotline at 1-877-436-5288. This toll-free hotline is available twenty-four (24) hours a day, seven (7) days a week. All reports received through the hotline will be reviewed according to Compliance Program policies and procedures and appropriate corrective actions will be taken. Providers may also report a compliance issue in writing to Missouri Care Compliance Program, 2404 Forum Blvd., Columbia, MO 65203.