

VI. SPECIALIST PHYSICIANS

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6.1 SPECIALIST'S RESPONSIBILITIES

Missouri Care contracted specialist physicians' (PSPs) responsibilities include but are not limited to:

1. Under the direction of the PSP, Covered Services shall be offered to members in accordance with customary standards of practice.
2. Provide Covered Services to members during the term of the Agreement pursuant to Missouri Care's prior authorization and referral policies as incorporated within the current Missouri Care Provider Manual. Failure to comply with Missouri Care prior authorization and referral policies may result in claim denial.
3. Verify the enrollment of the member prior to the provision of Covered Services. Failure to verify member enrollment may result in claim denial.
4. Refer members in accordance with Missouri Care prior authorization and referral policies as incorporated within this current Missouri Care Provider Manual. The PSP will maintain documentation of referrals including feedback and outcome of the referrals. Failure to comply with the Missouri Care prior authorization and referral policies may result in claim denial.
5. Maintain current DEA and BNDD numbers throughout the term of the Agreement and Missouri Care encourages PSP to record DEA and BNDD numbers on all prescriptions.
6. Prescribe or authorize the substitution of generic pharmaceuticals and agrees to abide with Missouri Care's Preferred Product List.
7. Agree to render services to members who are diagnosed as having human immunodeficiency virus (HIV) in the same manner and to the extent as other members.

8. Maintain active staff membership and admission privileges in good standing at a Missouri Care contracted hospital or other appropriately licensed contracted facility, unless specifically authorized by Missouri Care.
9. Admit members in need of hospitalization only to Missouri Care contracted hospitals or other appropriately licensed contracted facilities, 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 contracted hospital or other contracted facility is not feasible for medical reason. PSP agrees to provide Medically Necessary Covered Services to members while in a hospital or other facility.
10. Agree to refer or direct members to participating hospital emergency rooms for emergent care only. PSP shall make a concerted effort to educate and instruct members about the proper utilization of the PSP office in lieu of hospital emergency rooms.
11. 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.
12. Adhere to Missouri Care's managed care philosophy and principles, including the sharing of each member's relevant medical information with the member's assigned Primary Care Provider.
13. Encouraged to participate 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. Maintain in full force and effect and be covered at all times by professional liability insurance as well as the other insurance requirements as detailed by the Missouri Care provider contract.
16. Comply with federal regulations of the Occupational Safety and Health Administration including, with limitation, the regulations concerning Blood borne Pathogens Standards at 29 C.F.R. Part 1910.1030, which became effective January 1, 1992.

17. Responsible for bringing referred members into compliance with medical treatment plans. Missouri Care will work with PSP to facilitate appointment scheduling.
18. Comply with the Patient Self-Determination Act, which became effective December 1, 1991.
19. Abide by and follow Missouri Care's policies and procedures, including quality management and utilization management.
20. Identify and bill other third-party carriers or insurers first.
20. 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.
21. Perform and bill only for those lab tests for which provider is CLIA certified to perform in the office.

6.2 SPECIALIST'S OFFICE VISIT CHECKLIST

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

1. Verify the member's enrollment via the State Interactive Voice Response system (IVR) prior to initiating services and before rendering subsequent services.
2. Check the member's Missouri Care ID card each time the member presents for service and verify against secondary identification (with photo, if possible).
3. Verify that prior authorization and/or a properly completed referral form is available if needed prior to providing services.
4. Fax a copy of the referral form to the Missouri Care Prior Authorization Department if the PCP has not already done so.
5. Bill all services provided to a Missouri Care member on a HCFA-1500. Refer to Chapter XI for billing procedures.
6. Remember Missouri Care is the payor of last resort, bill other third party carriers or insurers first.
7. Send report of findings to the Primary Care Provider within a reasonable period of time.

6.3 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 the first visit // for patients age twenty-one (21) or over, who are 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 (Missouri Care Provider Manual.)
 - (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 initiated 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 (PRN). 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 of at least one of each vaccine. Immunization must be considered for all school age children without vaccine records.

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)
- (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 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.

6.4 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 date 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, and 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 make available access to all members' medical records within thirty (30) days should MC+ request any or all of them. MC+ is not required to obtain written approval from a member before requesting the member's record from the Provider or other Provider agency. 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.

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.

6.5 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, HIPPA, and State rules and regulations.

6.6 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. A third medical opinion may also be sought by the member in the event that the first two (2) opinions are at odds.

6.7 ADVANCE DIRECTIVES (PATIENT SELF DETERMINATION ACT)

The Patient Self-Determination Act of 1990 which 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.

6.8 RELEASE FOR ETHICAL REASONS

Missouri Care does not require a Provider to perform any treatment or procedure which 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.

6.9 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.

6.10 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)

6.11 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.