

Chapter 2. Participation with Mountain State

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2.1 Network Participation Requirements

2.1.1 Provider Agreements

Mountain State contracts with providers that have service locations within either the State of West Virginia or a contiguous county. Mountain State utilizes provider networks for all of its health benefit lines of business.

a. Types of Agreements

Professional providers sign a *Participation Agreement* for the indemnity network and a separate *Addendum to Participation Agreement* for the PPO/POS networks. Primary care physicians who act as care coordinators for members in our POS products also sign a *SuperBlue® Select Primary Care Physician Provider Agreement*. Participation in the FreedomBlue® network is governed by an *Amendment to Participation Agreement for Medicare Advantage PPO Program(s)*; for non-West Virginia providers not participating in Mountain State's commercial networks, this may be a stand alone agreement.

Hospitals and other facility and organizational providers typically sign one agreement covering indemnity, PPO and POS product lines and a separate agreement for Medicare Advantage.

b. Required or Elective Participation in Various Networks

New providers contracting with Mountain State are required to participate in our indemnity, PPO and POS networks. New providers are encouraged but are not required to participate in the Medicare Advantage FreedomBlue® network. Network providers may elect to opt out of the FreedomBlue® network by providing written notice to Mountain State pursuant to the Medicare Advantage amendment/agreement. The WWSBP uses the Mountain State commercial PPO network. Providers may opt out of the WWSBP but remain in the Mountain State PPO network through an annual opt out process administered by the PEIA.

Previously, some types of providers could contract to be in our indemnity network only. Presently, the vast majority of Mountain State members are enrolled in PPO benefit plans. Accordingly, to best serve our members and to make the network relationship most productive to the provider, Mountain State instituted the indemnity/PPO/POS network participation requirement in 2004.

Network providers who are currently contracted for the indemnity

network only will also be required to participate in all networks (except Medicare Advantage and WWSBP). Mountain State is in the process of contacting these providers to obtain contracts for the other (i.e., PPO, POS) networks.

c. Non-Retaliation for Exercise of Rights and Remedies

Providers are encouraged to become knowledgeable of the rights and remedies available to them under their agreement(s) with Mountain State, this *Provider Manual*, and other administrative policies and procedures. We encourage you to contact your External Provider Relations Representative or the Office of Provider Relations with any questions, concerns, or problems you may have regarding your relationship or interaction with Mountain State.

It is our policy to treat providers courteously, professionally, and fairly in all circumstances. Providers can be assured that they will not be subject to discriminatory treatment or retaliation in any form for exercising rights and remedies afforded them pursuant to their agreements with Mountain State.

d. Copies of Agreements

A provider who misplaces his/her agreements with Mountain State or is unsure whether he/she has the most complete or current version may obtain copies by contacting his/her External Provider Relations Representative or the Office of Provider Relations at 1-800-798-7768.

2.1.2 Provider Identification Numbers

At the time of contracting with Mountain State, network providers are assigned a “Performing Provider Number” and a “Billing Number.” The ID numbers are used to identify practice locations and billing or reimbursement addresses. For details on proper submission of provider ID numbers on claims, please see Chapter 7, Billing and Claims Processing of this *Provider Manual*.

Effective May 23, 2007, providers submitting electronic claims or other HIPAA standard transactions must use their National Provider Identifier (“NPI”). Information on how to obtain an NPI number can be found on our website at www.msbcbs.com.

2.1.3 Changes in Provider Information

a. Professional Providers

Each professional provider completes a *Provider Reimbursement/Change Form* when he/she initially contracts with Mountain State. This information is necessary to ensure that payment, the Provider Explanation of Benefits, and other information are directed to the correct address.

Examples of information on the form include:

- Name (group and individual);
- Tax Identification Number/NPI number;
- Addresses (street, billing);
- Telephone number(s); and
- Additional office locations.

Providers must notify Mountain State of any changes to their practice information by submitting updated information on the Provider Reimbursement/Change Form. Changes should be communicated at least 60 days in advance of the effective date.

The following is a list of changes that must be communicated to Mountain State in order to ensure that payments and other insurance-related information continue to be directed correctly:

- Practice location;
- Billing address;
- Tax identification number;
- NPI number;
- Practice name change;
- Individual provider name change;
- Individual provider number (“Pay To” or “Service”);
- Practitioners joining the practice;
- Practitioners leaving the practice (including through death);
- Practice mergers or acquisitions;
- Addition or closure of a practice site; and
- Medicare number.

The *Provider Reimbursement Form* can be printed from the Mountain State website at www.msbcbs.com (click on the “Provider” drop down bar and select “Forms”).

NOTE: Mountain State’s professional *Participation Agreement* may not be assigned or transferred without Mountain State’s prior written consent. If considering one of these options, please contact your External Provider Relations Representative or call the Office of Provider Relations at 1-800-798-7768.

Mail changes on the *Provider Reimbursement/Change Form* to:

Mountain State Blue Cross Blue Shield
Office of Provider Relations
P. O. Box 1948, 700 Market Square
Parkersburg, WV 26102

If you have any questions regarding changes to your practice information, please contact your External Provider Relations Representative or the Office of Provider Relations at 1-800-798-7768 or (304) 347-7717 for Medicare Advantage inquiries.

b. Facility/Organizational Providers

Network hospitals and other facility and organizational providers must provide written notice to the Office of Provider Contracting and Reimbursement if any of the following information changes:

- Name (group and individual);
- Tax Identification Number/NPI number;
- Ownership or sale;
- Service locations (new, closures);
- Addresses (service, billing, remittance);
- Telephone number(s);
- Services (changes in service, new service); and
- Medicare number.

Please address such notice either to the Mountain State address listed in your contract or to:

Mountain State Blue Cross Blue Shield
Office of Provider Contracting and Reimbursement
P. O. Box 1353, 900 Pennsylvania Avenue
Charleston, WV 25325

If you have any questions regarding changes to your facility/organizational provider information, please contact the Office of Provider Contracting and Reimbursement at (304) 347-7797 (indemnity, PPO, POS) or (304) 347-7717 for Medicare Advantage inquiries.

NOTE: Mountain State's provider agreements generally may not be assigned or

transferred without the prior written consent of Mountain State. In addition, some agreements afford Mountain State the right to limit or terminate an agreement in the event of any of the following: (1) sale of all or substantially all of the assets; (2) transfer of control of management or operations to a third party; or (3) change in control by acquisition, merger or otherwise.

Hospital agreements require the provider to notify Mountain State of new services or facilities so that reimbursement rates may be negotiated.

Facility and organizational providers should contact the Office of Provider Contracting and Reimbursement at least 60 days in advance of the effective date of any of the above actions so that appropriate consents can be obtained, continuation of the agreement arranged, or rates for new services established, as applicable.

2.1.4 Immediate Notification of Certain Actions

Providers of all types must provide immediate written notification to Mountain State in the event of any of the following:

- Termination, suspension, or limitation of license or certification;
- Exclusion, withdrawal, sanctions or other change in status regarding participation in federal health programs (Medicare, Medicaid, Federal Employee Health Benefit Plan, other programs);
- Change in accreditation status;
- Felony conviction;
- Labor strike or work stoppage; and
- Change in credentialing information.

Notice should be sent to:

For physicians, facilities and organizational providers:

Office of Network Credentialing Mountain State Blue Cross Blue Shield P. O. Box 1353, 900 Pennsylvania Avenue Charleston, WV 25325

For allied health providers:

<p>Office of Allied Health Credentialing Mountain State Blue Cross Blue Shield P. O. Box 1353, 900 Pennsylvania Avenue Charleston, WV 25325</p>

2.1.5 General Conditions of Participation

In order to participate in Mountain State's networks and the FreedomBlue® network, a provider must:

- Execute the appropriate network participation agreement(s) (which include the terms of payment), and complete fully any required application or information forms;
 - Abide by the terms and conditions of such agreement(s), including any amendments;
 - Satisfy and remain in compliance with applicable Mountain State credentialing and re-credentialing standards;
 - Cooperate and comply with Mountain State's health services management programs, including but not limited to: pre-certification, prior authorization, care and case management, disease management, clinical quality improvement, and other programs and initiatives that may be adopted from time to time;
 - Provide timely written responses to complaints or clinical quality issues upon request by Mountain State;
 - Follow Mountain State's appeals processes and other dispute resolution mechanisms; and
 - Adhere to Mountain State's billing, claims submission and other administrative guidelines and requirements, including this *Provider Manual*.
-

2.1.6 Open/Closed Networks

At present, Mountain State is accepting applications in any of its networks, with only a limited area closed to specific new provider types. This is in recognition of the general fact that, for many types of healthcare providers, West Virginia and the surrounding counties are underserved areas. Mountain State reserves the right, however, to close one or more of its networks to specific types of providers or to additional service locations if:

- Mountain State determines that it has contracted with a sufficient

number and distribution of providers to serve its members adequately;
or

- Mountain State determines that closing the network would otherwise be in the best interests of its members, the company, and network providers.

If Mountain State elects in the future to close a network, notice of such policy will be communicated in the *Provider News* and to providers who contact us about network participation or adding service locations.

2.2 Member Access to Physicians

2.2.1 Availability Standards

Mountain State’s Medical Advisory Committees, comprised of practicing network physicians, have approved availability standards as set forth in this Section 2.2. Network physicians, to the best of their ability, shall adhere to these standards in serving Mountain State members. Mountain State recognizes that many parts of its service area are medically underserved, and that this may make achievement of these standards difficult.

Mountain State may monitor compliance through member surveys, investigation of member complaints, mock telephone calls requesting an appointment or inquiring about after hours availability, review of provider office records and other means.

2.2.2 PCP and Specialist Standards

The table below illustrates standards for PCP and specialist accessibility.

PCP And Specialist Standards		
Patient’s Need	Definition	Performance Standard
Emergency/life threatening care	An emergency medical condition (as defined by the Balanced Budget Act [BBA] of 1997) is: A condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.	Immediate response upon notice or knowledge of the condition. Response could include referring patient to the Emergency Room.

PCP And Specialist Standards		
Patient's Need	Definition	Performance Standard
Urgent care appointments (e.g., high fever, persistent vomiting/diarrhea)	An urgently needed service is a medical condition that requires rapid clinical intervention as a result of an unforeseen illness, injury, or condition.	Within 24 hours
Regular and routine care appointments	<ul style="list-style-type: none"> • Routine care (symptomatic): Non-urgent care for symptomatic conditions (e.g. headache, cold, cough, rash, joint/muscle pain, etc.) • Routine wellness appointments (e.g., asymptomatic/preventive well child exams, physical exams, etc.) 	<ul style="list-style-type: none"> • Within 7 days • Within 30 days
After-hours care	Access to practitioner after the practice's regular business hours.	<p>24 hours a day / 7 days a week, by telephone</p> <p>Practitioners are encouraged to return calls within 30 minutes, barring extenuating circumstances. This includes covering physicians.</p>

2.2.3 Behavioral Health Care Standards

The table below illustrates standards for behavioral healthcare provider accessibility.

Behavioral Health Care Standards		
Patient's Need	Definition	Performance Standard
Care for a life-threatening emergency	Immediate intervention is required to prevent death or serious harm to patient or others.	Immediate response upon notice or knowledge of the condition. Response could include referring patient to the Emergency Room.
Care for a non-life-threatening emergency	Rapid intervention is required to prevent acute deterioration of the patient's clinical state that compromises patient safety.	Within 6 hours
Urgent care	Timely evaluation is needed to prevent deterioration of the patient's condition.	Within 48 hours
Routine office visit	Patient's condition is considered to be stable.	Within 10 business days

Behavioral Health Care Standards		
Patient's Need	Definition	Performance Standard
Telephone access to behavioral health screening and triage	Patient requires behavioral healthcare needs assessment.	Callers reach a non-recorded voice (operator) within 30 seconds Hang-up rates do not exceed 5%

2.2.4 Office Hours

Network physicians and allied health providers must maintain a minimum of 16 office hours per week during which the provider is available to see patients. Providers must maintain appointment hours which are sufficient and convenient to serve members and that do not discriminate against Medicare Advantage members relative to other members.

2.2.5 Patient Wait Times

Physicians are encouraged to see patients with scheduled appointments within 60 minutes of their scheduled appointment time. A reasonable attempt should be made to notify patients of delays.

2.2.6 After-Hours Accessibility

PCP and specialist practices must be available by telephone 24 hours a day, seven days a week, to direct patient care. The PCP, specialist or covering physician is encouraged to respond to after-hours calls within 30 minutes of the member's telephone call, barring extenuating circumstances.

Network physicians must have an established mechanism either to respond directly to members who contact the provider after office hours or to direct members to after-hour care options. Acceptable after-hours access mechanisms include:

- Answering service;
- On-call beeper; or
- Call forwarding to physician's home or other location.

2.2.7 Covering Arrangements

If a network physician will be unavailable to see patients, then he or she must arrange for a covering physician to take care of his/her patients during and after regular office hours. It is the responsibility of the network physician to ensure that any physician who is covering for him or her participates in the same Mountain State networks.

For both PCPs and Other Physicians

The physician should inform his/her office staff of a covering arrangement and also ask the covering physician to inform his/her office staff of such arrangement. In addition, the physician should ensure that his or her answering service informs patients of the arrangement.

PCPs in Mountain State's POS network select a back-up physician at the time of contracting with Mountain State, by completing the *SuperBlue® Select Point of Service Primary Care Physician Back-Up Physician Information Form*. The PCP may change his/her designated covering physician by submitting a new form. A copy of the form is reproduced at the end of this section. Use of a non-network physician for coverage must be authorized by Mountain State. Please contact the Office of Provider Relations at 1-800-798-7768.

PRIMARY CARE PHYSICIAN

**BACK-UP PHYSICIAN
INFORMATION FORM**

**PRIMARY CARE PHYSICIAN'S
MSBCBS PROVIDER OF SERVICE NUMBER** _____

**PRIMARY CARE PHYSICIAN'S
INDIVIDUAL NPI NUMBER** _____

**PRIMARY CARE PHYSICIAN'S
TELEPHONE NUMBER** _____

**PRIMARY CARE
PHYSICIAN'S NAME** _____

BACK-UP PHYSICIAN'S NAME _____

**BACK-UP PHYSICIAN'S
MSBCBS PROVIDER OF SERVICE NUMBER** _____

**BACK-UP PHYSICIAN'S
INDIVIDUAL NPI NUMBER** _____

DATE PROVIDER BECAME ACTIVE AS BACK-UP FOR THE PCP _____

DATE PROVIDER BECAME *INACTIVE AS BACK-UP FOR THE PCP _____

*Please notify the Provider Relations Department at 1-800-798-7768, X47795 of any changes regarding the Back-Up Physician.

THIS FORM MUST BE COMPLETED AND RETURNED WITH THE PRIMARY CARE PHYSICIAN AGREEMENT.

2.3 Primary Care Physicians

2.3.1 Who May Serve as a PCP

PCPs in the Mountain State networks play an important role in coordinating the healthcare for members who select their practice. A PCP (M.D. or D.O.) may be a family practice physician, general practitioner, internal medicine physician or pediatrician who meets Mountain State's credentialing standards.

2.3.2 How Members Select a PCP

Members in Mountain State's SuperBlue® Select POS plans are asked to select a PCP from the provider directory at the time of enrollment. Members are informed that if they do not select a PCP, benefits will be paid at the lower, self-referred level of benefits.

POS members may transfer to a different PCP by completing a *Primary Care Physician Selection Form*, available from Mountain State Customer Service. Members' PCP may be changed once a month. The PCP change will become effective upon request.

When a member chooses a new PCP, the prior PCP should transfer a copy of the member's medical records to the new PCP in a timely manner.

Members in Mountain State's PPO and indemnity plans (including SuperBlue® and New Blue®) and in FreedomBlue® Medicare Advantage plans are not required to formally select a PCP. These members may select or switch PCPs as they choose without notifying Mountain State.

2.3.3 Eligibility Roster

The *Eligibility Roster* is a list of SuperBlue® Select POS members currently enrolled with a specific primary care practice. Its purpose is to give PCPs a way to identify which members are assigned to their practice for any given month.

Rosters are mailed at the end of each month and contain enrollment information for the following month. Any changes based on member PCP selection will be reflected on the next roster issued following the change.

FIELD	Function
MEM (MEMBER) NUM (NUMBER)	Member number is a two-digit number that notes the member covered. For example: 00 = subscriber 01 = spouse or dependent 02 and up = additional dependents
GROUP NUMBER	Group number identifies the employer group or the benefit plan for which the member is eligible.
SEX	Shows the member's sex.
AGE	Shows the member's age.
BEGIN DATE	Begin date is the date the member enrolled with the provider under the given group number.
END DATE	End date is the date the member cancelled with the provider under the given group number.
FINANCIAL INDICATOR	Financial indicator will always be "F" for fee for service.
COPAY	Shows the co-payment that you may collect from the member for office visits.

2.3.4 PCP Responsibilities

PCPs in Mountain State's networks are responsible for the member's timely access to appropriate services, including but not limited to the following types of services as defined by the member's benefit coverage:

- Office visits;
- Inpatient hospital, emergency room, skilled nursing facility and home visits;
- Routine pediatric and adult immunizations;
- Maintenance allergy injections;
- Routine diagnostic procedures;
- Minor surgeries performed in the office;
- Lab services performed in the office;
- Preventive and early detection interventions;
- Most acute and chronic services;
- Other services as necessary;
- Maintaining organized medical record-keeping practices and ensuring accurate medical records;
- Maintaining active staff privileges at a Mountain State network hospital;
- Providing 24-hour telephone availability year-round;
- Providing physician coverage at all times;
- Obtaining authorization for services where required;

-
- Informing FreedomBlue® members about advance directives; and
 - Cooperating with Mountain State cost and quality management programs, including but not limited to the following:
 - ❖ Clinical initiatives and studies;
 - ❖ Condition management and shared decision-making;
 - ❖ Health Plan Employer Data and Information Set (HEDIS); and
 - ❖ Providing access to members' medical records.
-

2.3.5 Terminations of PCP/Patient Relationship

This section applies to POS only.

In the course of routine patient care, situations may arise in which the PCP believes that, despite his/her best efforts, he/she has not established an effective physician-patient relationship with a given member.

Such situations may include, but are not limited to, the following;

- The member is repeatedly non-compliant with plans of treatment or appointments established by the PCP.
- The member is abusive to the physician, the physician's office staff and/or the physician's other patients.
- The member is unwilling to follow reasonable procedures and guidelines regarding contacts with the physician and the use of the physician's facilities.
- The member continually fails to pay appropriate deductibles and co-payments or make reasonable arrangements for their payment. (Note: The threat of termination of the physician-patient relationship should not be used as part of the collection process for past due debts.)

When a PCP has exhausted his/her best efforts to establish an effective relationship and has documented situation(s) such as those described above, the PCP may apply to Mountain State to have the member transferred from the PCP's practice.

Written requests for physician/patient relationship termination should be submitted to:

Office Of Provider Relations
 Attention: Director
 Mountain State Blue Cross Blue Shield
 700 Market Square, P. O. Box 1948
 Parkersburg, WV 26102

Included with each request should be statements which document:

- The nature and timing of the incident(s) which gave rise to the request.
- The steps which the PCP has taken to resolve the situation and/or to establish an acceptable relationship with the member.
- Other relevant information pertinent to the request for terminating the physician-patient relationship.

Upon transfer of the member from the PCP's practice, the PCP agrees to transfer copies of the member's medical records, X-rays or other data to the receiving PCP upon written request by the member.

2.3.6 Closing/Reopening a Practice to New Members

Professional providers indicate on the *West Virginia Uniform Credentialing Form* at the time of initial credentialing, and also on the *Uniform Re-Credentialing Form* during re-credentialing, whether or not they are currently accepting new patients. This information is used by Mountain State to:

- Ensure that POS plan members do not select as their PCP a practitioner whose practice is closed to new members;
- Assess the adequacy of numbers and types of providers in Mountain State's networks; and
- Accurately advise members and providers who contact us seeking assistance in locating a network provider.

A PCP may close his/her practice to new POS members (excluding patients already in the practice who subsequently enroll in a POS plan) by providing at least 60 days prior written notice to Mountain State. A PCP may close his/her practice to new Mountain State members only if he/she is closing the practice to all new patients, unless this requirement is waived by Mountain State in writing. Notice should be mailed or faxed to:

Office of Provider Relations Mountain State Blue Cross Blue Shield P. O. Box 1948 Parkersburg, WV 26102 Fax: (304) 424-7713

When a PCP practice is "closed to new members," it means that the practice is temporarily not available for selection by new POS members. A "new" member is a

patient who has: (1) never been seen by a physician of the practice; or (2) not been seen by a physician of the practice within the past 36 months.

A PCP may reopen his/her practice by providing written notice to the same address indicated above.

Specialist physicians, allied health providers and other types of professional providers may close their practices to new Mountain State members only if the provider is closing his/her practice to all new patients (i.e., patients covered by all payors), unless this requirement is waived by Mountain State in writing. Professional providers other than PCPs are not required to provide advance notice to Mountain State of either closing or reopening their practices to new members. PCPs are required to provide notice of closing/reopening their practices for POS members only.

2.4 Timely Communication of Clinical Information

2.4.1 Purpose

Network PCPs, specialists, facilities and other providers must communicate with one another to ensure continuity and coordination of care for members. The goal is to ensure the exchange of necessary information in an effective, timely, and confidential manner to promote appropriate diagnosis and treatment for members.

2.4.2 PCP and Specialist Communication

PCPs and specialists, including medical, surgical, and behavioral health specialists, must communicate in each of the following ways in order to ensure continuity of patient care:

- Before the member's visit to the specialist, the PCP must provide relevant clinical information to the specialist. Acceptable forms of communication are formal letter and/or copies of relevant portions of the patient's medical chart.
- Within 10 business days of the first visit, the specialist must provide the PCP with information about his or her visit with the member. Acceptable methods of communication are standardized form, formal letter and/or copies of relevant portions of the patient's medical chart. For behavioral healthcare, the communication must occur within one week after the second visit and after treatment or condition changes.
- In the case of behavioral health, the member's consent may be needed for the behavioral health specialist to release information to the PCP. If a patient refuses to give consent, the behavioral health specialist must document this refusal in the patient's behavioral health treatment record.
- The PCP must document his or her review of the reports, lab, X-ray and other

diagnostic tests received from the specialist or healthcare facility in the patient's chart. The PCP must also indicate any subsequent action necessary. The PCP should indicate that he or she has reviewed the information (e.g., by initialing each page).

Sample communication forms are available on Mountain State's website at www.msbcbs.com. Click on the "Provider" drop down bar.

2.4.3 Facility and Organizational Provider Communication

Network facilities and other organizational providers, such as hospitals, emergency facilities, ambulatory surgery centers, home health agencies, and skilled nursing facilities, must promote continuity and coordination of care for members by communicating timely with PCPs when care is delivered to their patients. PCPs should expect a written description of the care given to their patients any time services have been rendered by these providers.

2.4.4 Member's Role in Communication

Neither PCPs nor specialists should ask members to communicate findings, reports, lab results, etc. to other providers.

2.4.5 Quality Assurance Monitoring

Mountain State will monitor compliance with coordination of care by a variety of methods. This may include medical record review, focused communication studies and periodic provider satisfaction surveys.

- Medical record review: Mountain State reviewers will check for the practitioner's initials on the patient's chart and ensure that any necessary follow-up actions are addressed.
 - Focused studies: PCP medical records of members who received services from a specialist are reviewed for the presence of communication from the specialist regarding the member's care.
-

2.5 Directing Care to Network Providers

2.5.1 General Obligation

Network providers in Mountain State's PPO and point of service ("POS") networks, including the FreedomBlue® Medicare Advantage network, must refer members who need additional, non-emergent services to other providers who participate in the network associated with the member's benefit plan (i.e. PPO, POS, FreedomBlue®). This protects the member from higher costs that may be incurred if services are received from a non-network provider.

A provider must seek prior authorization from Mountain State before referring a member to a non-network provider. To obtain an authorization, please call the Office of Medical Management at 1-800-269-6389 for FreedomBlue® members or 1-800-344-5245 for all other members. Prior approval is not required for treatment of emergency medical conditions. If a member seeks treatment at a hospital emergency room and receives services that are not medically necessary, Mountain State will not reimburse the cost of such services, other than a medical screening exam to determine if an emergency medical condition exists, or, if based on retrospective review, a prudent layperson would have believed an emergency medical condition existed.

2.5.2 Locating Network Providers

The most current provider directories for each Mountain State product and FreedomBlue® are posted on the Mountain State website at www.msbcbs.com (select the "Provider" drop down bar and click on "Provider Directories"). You may search by product, geographic location and specialty to locate network providers.

The website also provides a link to the Blue Cross Blue Shield Association BlueCard® Doctor and Hospital Finder. You may search this to locate network providers outside Mountain State's service area (i.e., nationally and internationally) for members who have BlueCard® benefits. (For more information on the BlueCard® program, see Chapter 7 of this *Provider Manual*.)

You may also contact the Office of Provider Relations at 1-800-798-7768, or the Office of Medical Management at 1-800-344-5245, and for Medicare Advantage at 1-800-269-6389, for assistance in locating network providers.

2.5.3 Types of Providers to Be Used

When more than one type of provider can furnish a particular service or item covered by the member's benefit plan, Mountain State generally does not restrict a member's or referring provider's choice of what type of provider to use. Consistent with state provider anti-discrimination law, Mountain State's plans do not impose limitations or conditions on services, diagnoses or treatment by a particular type of provider that do not apply equally to all types of licensed providers that customarily provide such services.

Mountain State's benefit plans do generally provide that services must be:

- Furnished by licensed (or certified, where applicable) providers practicing within the scope of their license;
 - Rendered according to generally accepted medical standards and practices;
 - Provided by someone other than an immediate family member; and
 - The most appropriate supply or level of service which can be safely and adequately provided to the member in the most cost-effective setting.
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2.5.4 Out of Network Services

If a treating provider cannot identify a physician or facility (whether in or out of network) to which to refer a patient (e.g., for highly-specialized, unusual, or infrequently-performed services), then the provider may contact the Mountain State Office of Medical Management, at 1-800-344-5245, for assistance.

Mountain State pre-certification or care management nurses (with assistance from a medical director, if needed) will attempt to identify one or more in-network providers that perform the service in question. If we cannot locate an in-network provider, we will contact sources such as teaching centers, consulting specialists or other plans to identify out-of-network providers that may perform the service. If the services are medically necessary, the Office of Medical Management will authorize use of an out-of-network provider and approve in-network benefits.

2.6 Medical Records

Network providers are required to maintain current, detailed, comprehensive and accurate medical records for each member to whom they provide services. The medical record is critical to ensuring the quality, coordination and continuity of care.

Mountain State has adopted the following standards for documentation and maintenance of member health records. These standards have been approved by the Mountain State Medical Advisory Committees, the voting members of which are practicing physicians in Mountain State's networks.

2.6.1 Documentation Standards

Each medical record shall contain:

- Biographical, demographic and other personally identifying information for the member;
 - Patient-identifying information on each page to ensure pages are not lost or misfiled;
 - Identification of the treating provider and the services he/she provided on each entry;
 - Date of each provider/patient encounter and date of each entry;
 - Information on allergies and adverse reactions or, if none, notation that the patient has no known allergies or history of adverse reactions;
 - Prescribed medications, including dosages and dates of initial or refill prescriptions;
 - Problem list, including significant illnesses and medical and psychological conditions;
 - Presenting complaints, working diagnoses and treatment plans;
 - History and physical examination for each encounter appropriate to the reason for the particular encounter;
 - Past medical history, examinations, treatments, social history and risk factors pertinent to developing a treatment plan;
 - Documentation that laboratory tests, other studies ordered and consultations are appropriate to the member's symptoms or condition, and that results have been reviewed and acted upon;
 - Documentation of required follow-up, including any diagnostic testing, treatment or education;
 - Documentation that information received from another provider has been reviewed and, where appropriate, acted upon;
 - Tracking and review of problems from previous visits, including management of chronic conditions;
 - Documentation sufficient to demonstrate the medical necessity and appropriateness of each service;
 - Copies of advance directives or documentation of discussions with adult patients about such directives;
 - Immunization records (for PCPs);
 - Documentation of tobacco or alcohol use, or substance abuse;
 - Documentation of member input into treatment plans and decisions;
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- Preventive services, referrals or counseling, where appropriate;
 - Copies of consents or releases, where required, for release of confidential health information; and
 - Legible entries.
-

2.6.2 Maintenance of Records

Medical records must be maintained in accordance with the following requirements:

- Each chart is labeled to allow for easy and timely retrieval by the provider or provider's staff to meet the patient's clinical needs;
 - Records are systematically and timely prepared, filed and stored; and
 - Safeguards are in place to protect the confidentiality of patient records and information.
-

2.6.3 Monitoring of Compliance

Mountain State will monitor compliance with medical record documentation and maintenance standards in a number of ways. These may include: site visits in connection with credentialing, collection of HEDIS or other data, or monitoring compliance with contract, regulatory or accreditation requirements; review of records in connection with billing audits or other provider monitoring activities; review of records in connection with investigation of quality of care concerns; investigation of complaints; and as part of quality improvement initiatives.

Providers whose records are not in compliance may be subject to written counseling, corrective action and follow-up reviews.

2.6.4 Medical Records Requests

Network providers are required to cooperate with and timely respond to requests for medical records from Mountain State. Records may be requested for a variety of reasons, including but not limited to:

- When we have insufficient information to determine the medical necessity and appropriateness of a claim;
- To evaluate the clinical quality of care provided to members;
- To evaluate the appropriateness of billing or level of utilization of services;
- To determine possible pre-existing conditions;

- To investigate complaints; or
- Appeals and audits.

Regulatory standards require health plans to make medical necessity determinations, request and review additional information, and process claims within strict timeframes. For this reason, it is important for providers to provide all relevant medical records within the timeframe stipulated in the written request. No response or a late response may result in a denial of payment.

Clinical quality of care issues are reviewed by a plan medical director and the Medical Advisory Committee, which is comprised of network physicians. Failure to provide records requested may result in a referral to the Credentials Committee for corrective action.

Billing reviews may determine whether services billed are documented and supported by the medical record. Mountain State reimburses only for medically necessary covered services. Failure to furnish requested medical records may result in Mountain State recouping prior payments.

Mountain State's procedures for requesting and using medical records are designed to avoid multiple requests for the same records, request only the minimum necessary records, and protect the confidentiality of information and the privacy of individuals.

As a HIPAA covered entity, Mountain State has established as its policy regarding routine member consent that it will not request or obtain consent of its members in connection with the use or disclosure of protected health information ("PHI") for treatment, payment or healthcare operations. For certain situations, a member may need to give consent to use or disclose specific PHI. This includes: psychotherapy notes; substance abuse; or sensitive diagnoses such as HIV, STD or AIDS. Providers asked to submit medical records are responsible for obtaining member consent and should submit it to Mountain State along with the requested documents, as payment for services provided are specifically conditioned upon receipt of supporting documentation.

By contract, network providers are not reimbursed for supplying medical records to Mountain State, unless provided otherwise.

2.7 Involving Members in Their Health Care Decisions

2.7.1 General Obligation

In addition to the more detailed requirements stated in this section, Mountain State and providers must continually work together to encourage and support members taking an active role in their healthcare by:

- Providing consideration for member input when developing treatment plans;
 - Informing members of appropriate follow-up care;
 - Arranging or providing training in self-care and other measures that impact health status; and
 - Addressing barriers to member compliance with prescribed treatments or regimens.
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2.7.2 Advising Members of Treatment Options

Mountain State fully encourages and supports efforts by network physicians and other treating professional providers to provide advice and counsel and to freely communicate with patients on all medically necessary treatment options available, including medication treatment options that may be appropriate for the member's condition or disease, regardless of benefit coverage limitations.

Mountain State does not prohibit or otherwise restrict a healthcare professional, acting within the lawful scope of practice, from advising, or advocating on behalf of, an individual who is a patient and enrolled under a Mountain State plan, about:

- The patient's health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to the individual to provide an opportunity to decide among all relevant treatment options;
- The risks, benefits, and consequences of treatment or non-treatment; or
- The opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.

Some insurance companies may include a "gag clause" in their provider contracts that limits a network provider's ability to give full counsel and advice to enrollees. Mountain State's network contracts for all products do not (and never did) contain such a "gag clause" relating to treatment advice.

In cases where the care, services or supplies are needed from a provider who does not participate with Mountain State, authorization must be requested. To obtain authorization, the referring provider should call the pre-certification/pre-authorization telephone number on the back of the member's ID card.

2.7.3 Advance Directives

a. Applicability

Network providers are required to comply with the requirements of this section with respect to their FreedomBlue® Medicare Advantage member patients. Providers are urged to adhere to these same standards with respect to their other Mountain State patients in all types of plans.

b. Definitions

Advance directives are written instructions, such as living wills and medical (or durable) powers of attorney, recognized under state law and signed by a patient, that explain the patient's wishes concerning the provision of healthcare if the patient becomes incapacitated and is unable to make those decisions known.

A **medical (or durable) power of attorney** is a witnessed, notarized statement by which an individual appoints someone (typically a family member or trusted friend) to make healthcare decisions on the individual's behalf in the event that the individual becomes unable to make such decisions. If called to act, the appointed representative is to make decisions consistent with the wishes and values of the incapacitated individual, and to act in the individual's best interest where such wishes are unknown.

A **living will** is a witnessed, notarized statement by which an individual specifies in advance what life-prolonging measures or other medical care he/she wants, or does not want, in the event the individual: (1) is certified by one or more examining physicians to have a terminal condition or to be in a persistent vegetative state; and (2) is unable to communicate his/her wishes.

Some advance directives combine the functions of both a medical power of attorney and a living will.

c. Availability

Copies of medical power of attorney and living will forms recognized under West Virginia law are reproduced at the end of this section. For additional copies or more information about advance directives in West Virginia, providers may contact the West Virginia Bureau of Senior Services at 1-304-558-3317, or the West Virginia Center for End-of-Life Care at 1-877-209-8086.

Providers located in other states should contact their state health department,

professional licensing board, health facility licensing agency, Medicare survey and certification agency, or legal counsel to learn the requirements for advance directives in their state and to obtain forms, if available.

Providers may direct their patients who request additional information about advance directives to the West Virginia Bureau of Senior Services or the West Virginia Center for End-of-Life Care, at the telephone numbers listed above or similar other state agencies for members residing outside of West Virginia. In addition, Mountain State members may contact Blues on Call at 1-888-258-2428 for general (i.e., not state-specific) educational information on advance directives.

d. Mountain State Responsibilities

Highmark Health Insurance Company, through Mountain State, provides FreedomBlue® Medicare Advantage members, at the time of initial enrollment, written information on their rights to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.

Members are informed that complaints alleging denial of care or provision of care not authorized by an advance directive, or discrimination based on the existence of a directive, may be filed with the West Virginia Bureau of Public Health, Office of Health Facility Licensure and Certification, at 1-304-558-0050.

Mountain State may monitor compliance with this section by review of a provider's medical records during a site visit.

e. Provider Responsibilities

Network providers must:

- Discuss with Medicare Advantage members whether they have executed an advance directive;
- Document in a prominent part of the member's current medical record whether or not he/she has executed an advance directive;
- If the member has an advance directive, place a copy in a prominent part of the individual's medical record; and
- Review the contents of the advance directive, if a patient has one.

If a provider cannot implement an advance directive, in whole or in part, as a matter of conscience, then the provider must:

- Issue a clear and precise written statement of this limitation,

describing the range of medical conditions or procedures affected by the conscientious objection;

- Discuss this with the patient and document the discussion in a prominent part of the individual's medical record; and
- Assist the member in locating another network provider, if the member so desires, or contact Mountain State Customer Service at the telephone number located on the back of the member's ID card, so that we may assist in locating another network provider.

A provider may not condition the provision of care or otherwise discriminate against a FreedomBlue® or Mountain State member based on whether or not the individual has executed an advance directive.

**STATE OF WEST VIRGINIA
MEDICAL POWER OF ATTORNEY**

The Person I Want to Make Health Care Decisions
For Me When I Can't Make Them for Myself

Dated: _____, 20 ____ I, _____, hereby
(Insert your name and address)

appoint as my representative to act on my behalf to give, withhold or withdraw informed consent to healthcare decisions in the event that I am not able to do so myself.

The person I choose as my representative is:

(Insert the name, address, area code and telephone number of the person you wish to designate as your representative)

The person I choose as my successor representative is:

If my representative is unable, unwilling or disqualified to serve, then I appoint

(Insert the name, address, area code and telephone number of the person you wish to designate as your successor representative)

This appointment shall extend to, but not be limited to, healthcare decisions relating to medical treatment, surgical treatment, nursing care, medication, hospitalization, care and treatment in a nursing home or other facility, and home healthcare. The representative appointed by this document is specifically authorized to be granted access to my medical records and other health information and to act on my behalf to consent to, refuse or withdraw any and all medical treatment or diagnostic procedures, or autopsy if my representative determines that I, if able to do so, would consent to, refuse or withdraw such treatment or procedures. Such authority shall include, but not be limited to, decisions regarding the withholding or withdrawal of life-prolonging interventions.

I appoint this representative because I believe this person understands my wishes and values and will act to carry into effect the healthcare decisions that I would make if I were able to do so, and because I also believe that this person will act in my best interest when my wishes are unknown. It is my intent that my family, my physician and all legal authorities be bound by the decisions that are made by the representative appointed by this document, and it is my intent that these decisions should not be the subject of review by any healthcare provider or administrative or judicial agency.

It is my intent that this document be legally binding and effective and that this document be taken as a formal statement of my desire concerning the method by which any healthcare decision should be made on my behalf during any period when I am unable to make such decisions.

STATE OF WEST VIRGINIA LIVING WILL

The Kind of Medical Treatment I Want and Don't Want If I Have a Terminal Condition or Am In a Persistent Vegetative State

Living will made this _____ day of _____ (month, year). I, _____, being of sound mind, willfully and voluntarily declare that I want my wishes to be respected if I am very sick and not able to communicate my wishes for myself. In the absence of my ability to give directions regarding the use of life-prolonging medical intervention, it is my desire that my dying shall not be prolonged under the following circumstances:

If I am very sick and not able to communicate my wishes for myself and I am certified by one physician who has personally examined me, to have a terminal condition or to be in a persistent vegetative state (I am unconscious and am neither aware of my environment nor able to interact with others,) I direct that life-prolonging medical intervention that would serve solely to prolong the dying process or maintain me in a persistent vegetative state be withheld or withdrawn. I want to be allowed to die naturally and only be given medications or other medical procedures necessary to keep me comfortable. I want to receive as much medication as is necessary to alleviate my pain.

I give the following SPECIAL DIRECTIVES OR LIMITATIONS: (Comments about tube feedings, breathing machines, cardiopulmonary resuscitation, dialysis, and mental health treatment may be placed here. My failure to provide special directives or limitations does not mean that I want or refuse certain treatments.)

It is my intention that this living will be honored as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences resulting from such refusal.

I understand the full import of this living will.

Signed
Address

2.8 Preventive Care Responsibilities of Network Physicians

Network physicians have a unique opportunity to recommend or administer certain services and lifestyle improvements that can help prevent future illness or injury. Benefits are provided for prevention, early detection, and minimization of ill effects and causes of diseases. Mountain State encourages network PCPs and specialists to promote and help maintain the health of members through use of the preventive services and guidelines noted below.

2.8.1 PCP Responsibilities

PCPs in Mountain State's networks and the FreedomBlue® network should:

- Follow nationally accepted preventive health guidelines as provided by Mountain State.
 - Administer childhood and adolescent immunizations.
 - Administer influenza and pneumococcal vaccines to at risk and age-appropriate members.
 - Inform FreedomBlue® members about advance directives.
 - Provide timely and comprehensive well-care exams.
 - Use the Blues On Call SMART™ Registry to identify members with chronic conditions who have not received recommended preventive care and follow up to recommend or arrange for such care.
-

2.8.2 PCP and OB/GYN Responsibilities

PCPs and OB/GYNs in Mountain State's networks should:

- Provide or recommend screening mammograms, cervical cancer screenings and Chlamydia screenings.
- Provide or recommend prenatal care, especially in the first trimester.
- When appropriate, refer high-risk pregnant members to the Blues On Call condition management program.
- Provide or recommend post-partum exams by the 42nd day after delivery.
- Provide appropriate counseling for menopause.
- Evaluate the risk of child abuse, domestic violence and elder abuse.

2.8.3 PCP and Specialist Responsibilities

PCPs and specialists in Mountain State's networks should:

- Provide or recommend beta-blocker treatment after heart attack and promote long-term therapy, unless contra-indicated.
- Recommend and promote timely and age-appropriate preventive services, e.g., screening for breast, cervical, colorectal and prostate cancers.
- Recommend a follow-up behavioral health visit within 7 days and no later than 30 days after hospitalization for mental illness and ensure compliance with medication and long-term follow-up.
- Evaluate members to determine tobacco use. Advise and assist members to cease.
- Recommend the Dr. Dean Ornish Program for Reversing Heart Disease® and the Ornish Advantage educational program to members with heart disease or at risk members who could benefit from these programs.
- Provide or recommend adequate care for diabetic members, including foot and eye exams.
- Use recommended depression screening tools to identify depression in patients and initiate appropriate, ongoing treatment.
- When appropriate, refer members to the Blues On Call condition management programs for coronary artery disease, congestive heart failure, diabetes, chronic obstructive pulmonary disease and asthma.
- Provide appropriate and comprehensive care for members with hypertension.
- Prescribe appropriate medications for members based on current national standards of care.
- Promote exercise and physical activity to all patients, especially the senior population.

2.8.4 Coverage

Coverage for particular preventive services depends on the individual member's benefit plan. In POS plans, certain preventive services may be covered only if performed by the member's PCP. A provider may verify coverage by contacting the Customer Service telephone number on the back of the member's ID card or via NaviNetSM.

2.8.5 Documentation

Network physicians should submit accurate claim forms and document their preventive care services and recommendations in the member's chart. If performed by a specialist, the interventions, the dates they were performed and the results should be

communicated in writing to the PCP. Likewise, information about such interventions performed by the PCP should be communicated to the specialist when the information is pertinent to the condition the specialist is treating.

2.8.6 Preventive Health and Clinical Practice Guidelines

On an annual basis, the Mountain State Health Services Department, working with the Highmark Quality Management Department and with the practicing physicians serving on our Medical Advisory Committees, reviews and updates our preventive health and clinical practice guidelines. These guidelines are available online to the provider community as a reference tool to encourage and assist you in planning your patients' care. The guidelines may be found at www.msbcbs.com by clicking on the "Provider" drop down menu.

2.9 Other Provider Responsibilities

2.9.1 Non-Discrimination in Treatment of Members

Network providers agree not to discriminate in the treatment of Mountain State or FreedomBlue® members, or in the quality of services delivered, on the basis of place of residence, health status, race, color, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, or source of payment.

Complaints will be investigated by the Office of Network Credentialing or the Office of Allied Health Credentialing as appropriate, and referred to the Medical Advisory Committee and/or Credentialing Committee for appropriate action.

2.9.2 Providing Services in Culturally Competent Manner

Network providers must ensure that services, both clinical and non-clinical, are provided in a culturally competent manner to all members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. Mountain State may be able to assist a provider to locate translator or interpreter services for members who are non-English speaking or hearing impaired. The provider or member should call the Mountain State Customer Service telephone number located on the back of the member's I.D. card.
