

Chapter 2

Rights and Responsibilities of Physicians/Providers

Overview

This chapter outlines the rights and responsibilities of participating physicians and providers.

South Country Health Alliance (SCHA/MMSI) has adopted certain rules for participating providers in order to protect our members and to be in compliance with the requirements of regulatory agencies and accrediting bodies. This is not an all-inclusive list of rights and responsibilities, as additional responsibilities are presented elsewhere in this manual as well as in the provider agreement. Physicians/providers must demonstrate or agree to the following:

- That they have earned a professional degree and have a current, unrestricted license to practice medicine in the state in which the physician services are regularly provided.
- That they have been credentialed by SCHA/MMSI or delegated entity as required.
- That they can document their experience, background, training, ability, malpractice claims history, disciplinary actions or sanctions, and physician/mental health status for credentialing purposes.
- That they possess a current, unrestricted Drug Enforcement Administration (DEA) certificate, if applicable.
- That they are a medical staff member in good standing with a participating hospital(s), if he/she makes plan member rounds, and have no record of hospital privileges being reduced, denied, or restricted; or if so, provide an explanation that is acceptable to SCHA/MMSI.
- That they will inform SCHA/MMSI in writing within 24 hours of any revocation or suspension of his/her Bureau of Narcotics and Dangerous Drugs number, and/or of suspension, limitation, or revocation of his/her license, reduction or denial of hospital privileges, certification, Clinical Laboratory Improvement Amendment certificate, or other legal credential authorizing him/her to practice in that state.
- That they will inform SCHA/MMSI immediately of changes in licensure status, tax identification numbers, telephone numbers, addresses, status at participating hospitals, provider status (additions or deletions from physician/provider practice), loss or decrease in amounts of liability

insurance, and any other change which would affect his/her status with SCHA/MMSI.

- That they will not discriminate based on the member's health status.
- That they will not discriminate in any manner between SCHA members and non-SCHA members.
- That they will inform members regarding follow-up care or provide training in self care as required.
- That they will assure the availability of physician services to members 24 hours a day, 7 days a week (required by SCHA/MMSI Primary Care Clinics [PCC]).
- That they will arrange for on-call and after-hours coverage by a participating and credentialed SCHA/MMSI physician.
- That they will refer SCHA members with problems outside his/her normal scope of practice for consultation and/or care to appropriate specialists contracted with SCHA/MMSI and will do so on a timely basis.
- That they will refer members to participating physicians/providers, except when they are not available or in an emergency.
- That they will admit members only to participating hospitals, skilled nursing facilities (SNF) and other inpatient care facilities, except in an emergency, and/or work with hospital-based physicians in possible cases for acute hospital care.
- That they will not bill, charge, nor seek reimbursement from an SCHA member or enrollee other than for co-payments, or fees for non-covered services furnished on a fee-for-service basis, unless the member has signed a waiver form prior to the service. Non-covered services are services not included in the member's Certificate of Coverage.
- That they will provide services in a culturally competent manner. Care and services should accommodate the special needs of ethnic, cultural, and social circumstances of the member, including the removal of any language barriers.
- That they will provide or arrange for continued treatment to all members, including but not limited to medication therapy, upon expiration or termination of physician/provider agreement.
- That they will retain all contracts, books, documents, papers, and medical records related to the provision of services to plan members as required by state and federal laws.
- That they will treat all member records and information in a confidential manner, and not release such information without the written consent of the member, except as needed for compliance with state and federal law, including HIPAA regulations.
- That they will transfer copies of medical records to other SCHA/MMSI physicians/providers upon request and at no charge to SCHA/MMSI, the member, or the requesting party, unless otherwise agreed upon.
- That they agree to provide access to SCHA/MMSI or its designee to examine the provider office's patient billing records and/or medical records. This is necessary in order for SCHA/MMSI to guarantee

compliance with all financial, operational, quality assurance, and peer review obligations, as well as any other physician/provider obligations stated in a physician/provider agreement with SCHA/MMSI.

- That the sponsoring physician will assume full responsibility to the extent of the law when supervising PAs, ARNPs, and individuals other than physicians whose scope of practice should not extend beyond statutory limitations.
- That they will submit a report of an encounter for each visit where the member is seen by the physician/provider if the member receives a HEDIS[®] service.
- That they meet the requirements of all applicable state and federal laws and regulations including Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and the Rehabilitation Act of 1973.
- That they will notify MMSI on admission of scheduled surgeries/procedures requiring inpatient hospitalization on admission.
- That they will notify SCHA/MMSI of any material change in physician/provider's performance of delegated functions, if applicable.
- That they will notify SCHA/MMSI of his/her termination in a timely manner prior to the effective date of termination.
- That they will cooperate with an independent review organization's activities pertaining to the provision of services for Medicaid and Minnesota Care members. They will respond promptly to SCHA/MMSI requests for medical records or any other documents in order to comply with regulatory requirements, and to provide any additional information about a case in which a member has filed a grievance or appeal.
- That they will abide by the rules and regulations and all other lawful standards and policies of SCHA/MMSI plans.
- That they understand and agree that nothing contained in the physician/provider agreement or this manual is intended to interfere with or hinder in any way the communication between the provider and the member regarding a member's medical condition or available treatment options, nor to dictate medical judgment.
- Providers are required to inform all adult patients about their right to accept or refuse medical treatment as well as the right to execute an advance directive. Providers must:
 - ❖ Document in the medical record whether or not an individual has executed an advance directive.
 - ❖ Documentation is a prominent part of the member's current medical record whether or not the member has executed an advance directive. If not executed, there is documentation that advance directive information was offered.
 - ❖ Not condition treatment or otherwise discriminate on the basis of whether an individual has executed an advance directive.

- ❖ Comply with State law, whether statutory or recognized by the courts of the State, on advance directives, including Laws of Minnesota 1998, Chapter 399, Section 38.

In addition, network providers are responsible to inform patients they may file a complaint with the Minnesota Department of Health (MDH) regarding noncompliance with advance directive requirements.

Record Retention and Preservation

The provider must retain clinical record information for ten years after member discharge and must make provision for the maintenance of such records in the event that the provider is no longer able to treat patients.

MEDICAL RECORD REQUIREMENTS

Confidentiality/Release of information

- Staff receives periodic training in confidentiality of protected health information.
- Authorization must be present to release private information. Information obtained from outside sources must also be documented in the medical record.

Record Identity/Storage

- Medical records are stored in a secure area that is inaccessible to unauthorized individuals.
- Clinics with more than one practitioner have a tracking system place to ensure chart availability.
- There is a separate medical record for each patient.
- Each medical record is clearly marked with the patient name and/or medical record number.

Record Content

- All entries and medical notes are dated.
- All entries and medical notes must identify the author.
- The record is legible to someone other than the writer.
- Contents of the medical record are affixed and organized in a consistent manner.
- Demographic data includes member address, phone number, name and telephone numbers of emergency contact, and name and telephone number of member's guardian.
- Telephone orders and prescription refills are documented in the record.
- Nurse triage calls are documented in the record.

- A medication record is updated at every visit and includes name of medication (prescription, over-the-counter, herbal and vitamin supplements), dosage, amount dispensed and dispensing instructions.
- The presence or absence of allergies is clearly noted on the patient's record and includes adverse reactions.
- The record contains a problem list which lists both acute and chronic conditions, past medical history, listing of serious accidents, operations, and illnesses for patients who have been seen three or more times. For patients under 18 years, their past medical history includes prenatal care, birth, operations, and childhood illnesses.
- For patients who are 12 years or older, there is an appropriate notation concerning the use of alcohol and other substances (for patients who have been seen three or more times, check for substance abuse history).
- Documentation of the member's social history and family history is present in the medical record and updated at least every 5 years.
- Each entry in the medical record contains the length of time spent with the member if the amount paid for the service depends on time.
- Healthcare Directives are documented in the medical record for patient's 18 years and older.

Preventive Screening and Services

- Body Mass Index (BMI) for all ages is documented annually.
- The record contains Immunizations and is up to date.
- There is evidence that preventive screening and services are offered in accordance with the organizations practice guidelines.
- Tobacco status or exposure to second-hand smoke is documented in the medical record. If patient is a tobacco user advice regarding cessation is provided.

Assessment, Plan and Follow-up

- The history and physical exam identifies appropriate subjective and objective information pertinent to the patient's presenting complaints.
- Assessment of each encounter reflects patient's chief complaint.
- Results of all diagnostic tests/examinations are noted in the record.
- Treatment plans are consistent with diagnoses.
- There is no evidence the member is placed at inappropriate risk by a diagnostic or therapeutic procedure.
- Working diagnoses are consistent with findings.
- A consultation note is present for each consult requested, unless there is documentation that the member declined the release.
- All lab reports, imaging reports, special studies and consultations are reviewed and initialed by a practitioner.

- Appropriate follow-up care is documented in the medical record. (Encounter forms or notes include information about follow-up care, calls or visits when indicated). Specific time of return is noted in weeks, months or as needed.
- Patient hospitalization records are placed in the medical record within six weeks of discharge, which include the discharge summary and operative reports, as appropriate.
- Information on coordination of care, as appropriate, with other agencies is documented in the medical record.

Behavioral Health Record Content

- A psychiatric history is documented, including previous treatment dates, provider identification, therapeutic interventions and responses, sources of clinical data and relevant family information.
- Presenting problem(s), along with relevant psychological and social conditions affecting the member's medical or psychiatric status, are documented.
- Results of a mental status exam are documented.
- Special status situations, when present, are prominently noted.
- Evidence of coordination of care with other relevant behavioral health providers and/or medical professionals must be documented.
- Progress notes describe member strengths and limitations in achieving treatment plan goals and objectives.

Organizational Policies

- There is a written policy that ensures confidentiality of patient medical information.
- There is a written policy that addresses the procedure regarding release of information.
- There a written policy addressing HIPAA requirements.
- There a written policy addressing retention of medical records for a minimum of 10 years.
- There is a written policy and procedure in place to monitor Fraud, Waste and Abuse.