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) has adopted certain rules for participating providers in order to protect our members and to be in compliance with the requirements of federal and state regulatory agencies and accrediting bodies. Providers participating in SCHA's network agree to the following rights and responsibilities; note this is not an all-inclusive list, as additional responsibilities are presented elsewhere in this manual as well as in the provider's Participation Agreement with SCHA.

- Demonstrate evidence of a professional degree and have a current, unrestricted license to practice medicine in the state in which the services are regularly provided.
- Services must be provided to members by trained health care professionals acting within the scope of an appropriate license, certification, or registration.
- Complete the necessary credentialing by SCHA or a delegated entity as applicable.
- Document their experience, background, training, ability, malpractice claims history, and disciplinary actions or sanctions for credentialing purposes.
- Possess a current, unrestricted Drug Enforcement Administration (DEA) certificate, if applicable.
- For medical staff members, remain in good standing with a participating hospital(s), and have no record of hospital privileges being reduced, denied, or restricted; or if so, provide an explanation that is acceptable to SCHA.
- Inform SCHA 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.
- Inform SCHA 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.
- Not differentiate or discriminate in the treatment of members because of race, color, national origin, creed, religion, sexual orientation, public assistance status, age, disability (including physical or mental impairment), marital status, sex (including sex stereotypes and gender identity), political beliefs, medical condition, health status, receipt of health care services, claims experience, medical history, or genetic information.
- Inform members regarding follow-up care or provide training in self care as required, regardless of benefit coverage.

- Provider agrees that, to the extent feasible, services will be made available and accessible to members promptly and in a manner which assures continuity of care. Refer SCHA members with problems outside his/her normal scope of practice for consultation and/or care to appropriate specialists contracted with SCHA and will do so in a timely manner.
- Refer members to SCHA's network of participating providers, except when they are not available or in an emergency.
- 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.
- Refrain from billing, charging, or otherwise seeking reimbursement from member's other than for co-payments and/or deductibles, 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 Member Handbook / Evidence of Coverage.
- Provide information regarding treatment options in a culturally-competent manner, including member's rights to accept or refuse treatment and, if applicable, execute an Advance Directive. Provider must ensure that individuals with disabilities and limited English Proficiency have effective communications with physicians and health care professionals in making decisions regarding treatment options.
- Provide or arrange for continued treatment to all members, including but not limited to medication therapy, upon expiration or termination of their Agreement with SCHA.
- 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.
- 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.
- Transfer copies of medical records to other SCHA network participating providers upon request and at no charge to SCHA, the member, or the requesting party, unless otherwise agreed upon.
- Provide access to SCHA or its designee to examine the provider office's patient billing records and/or medical records. This is necessary in order for SCHA to guarantee compliance with all financial, operational, quality assurance, HEDIS, and peer review obligations, as well as any other provider obligations stated in an Agreement with SCHA.
- 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.
- 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 of 1990, Health Insurance Portability and Accountability Act of 1996, and the Rehabilitation Act of 1973.
- Notify SCHA on admission of scheduled surgeries/procedures requiring inpatient hospitalization on admission.
- Notify SCHA of any material change in performance of delegated functions, if applicable.

- Notify SCHA of provider terminations in a timely manner prior to the effective date of termination.
- Cooperate with an independent review of the organization's activities pertaining to the provision of services for Medicaid and Minnesota Care members. They will respond promptly to SCHA 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.
- Abide by the rules and regulations and all other lawful standards and policies of SCHA plans.
- Understand and agree that nothing contained in the SCHA Participation 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.
- Comply with all federal and state confidentiality, privacy and Enrollee record accuracy laws and regulations.

Healthcare Directives

Providers are required to inform all adult patients (18 and older) about their right to accept or refuse medical or surgical treatment as well as the right to execute a healthcare advance directive. Providers must:

- Document in a prominent part of the member's current medical record whether or not the member has executed a healthcare directive. If not executed, there is documentation that healthcare directive information was offered.
- Not condition treatment or otherwise discriminate on the basis of whether an individual has executed a healthcare directive.
- Update information to reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the State law.
- Comply with State law, whether statutory or recognized by the courts of the State, on advance directives, as defined in 42 CFR §489.100.
- Inform patients they may file a complaint with the Minnesota Department of Health (MDH) regarding noncompliance with a healthcare directive requirement.

Record Retention and Preservation

- 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.

Confidentiality/Release of information

- Ensure that facility 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 must be dated and 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 10 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.
- For patients who are 13 years or older there is screening and Brief intervention and Referral to Treatment (SBIRT) to identify unhealthy substance use, using a standard tool.

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.

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.
- For members 12 and older there is appropriate notation concerning past and present use of tobacco and alcohol as well as illicit prescribed and over the counter drugs, as well as present caffeine use.

Organizational Policies

- There is a written policy that ensures the organization's compliance with patient rights and a patient complaint system.
- 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 is a written policy addressing HIPAA requirements.
- There is 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.
- There is a written policy to support the organization's Quality Management program, including a written program description and work plan.