What is the right age to consider changing from a pediatrician to an adult health care provider? Many parents struggle with knowing when to make the change. It is an important decision and you can help. Depending on the child’s level of comfort or if there are special health care needs, they may need more time. Generally ages 18-21, the conversation will begin the conversation with the pediatrician about finding a physician. It should be a smooth transition. Talk with your patients when the time does come.

Inside this issue ...

Claims Submissions .................... 2
Spirometry Testing & COPD .......... 3
Member Rights .......................... 3
CMS Training Requirements ........ 3
Requesting Medical Records ........ 3
Exceptions to the Stark Law ....... 4
Genetic Testing .......................... 5
Coding Your Experience ............. 5
Medicaid Behavioral Health Codes ... 5
Opioid Calculator ...................... 6
D-SNP Provider Training .......... 6
Improving Communication .......... 7
THP’s Affirmative Statement ....... 7
Introducing Epocrates ................ 7
Signatures and Credentials ........ 7
How Does a Provider Impact Star Ratings? .......... 8
Fraud Alert Compounded Pain Cream Scams 8

Medical Management Review Criteria

Nationally recognized clinical criteria is utilized to perform reviews for medical appropriateness. This allows for consideration of the needs of the individual members, their circumstances, medical history, and availability of care and services within The Heath Plan network. Annually or as needed, input is sought in the review of criteria from physicians participating in the Physician Advisory Committee.

The Health Plan utilizes McKesson InterQual® criteria as a screening guideline to assist the nurse reviewers with respect to medical appropriateness of health care services, including behavioral health. Any participating provider may, upon request, review the specific criteria used in an active clinical review process of a procedure requiring the use of InterQual®.

InterQual® may be utilized to assist in the review of admissions, as well as surgical and radiological procedures including, but not limited to, MRI, MRA, CT scan, hysterectomy, ECT and psychological testing.

You may call The Health Plan Medical Department at 740.695.7643 or 1.800.624.6961, ext. 7643 or 7644, or Behavioral Health Services at ext. 7896, if you have a general InterQual® question or a question regarding a particular case. InterQual® review worksheets are available upon request.

Please indicate if your request is emergent so that we may expedite the review.

Simply scheduling the testing/procedure does not warrant an expedited review. Unless an emergency, scheduling should be done after being approved by The Health Plan.
Claims Submissions
CMS is Looking Closely at Duplicate Claims Submissions

THP claims analysts are seeing a marked increase in duplicate billing. To save your staff time and your practice money, THP recommends utilizing a free tool to reconcile your aging claims prior to resubmitting a claim. Claims payment is within 30 days of THP’s receipt of the claim. Resubmitting claims prior to 45 days from the original claim submission date further delays claims processing and payment. THP has a secure provider website that allows you to access your payment vouchers that detail all claims paid, denied and in-process going back 24 months. If you have not registered for this free tool, please register at: https://www.healthplan.org/providers. Allow five business days to receive an email from THP to access. Please contact THP’s Provider Relations Department at 1.877.847.7901 for assistance with this tool.

CMS recently announced that in an effort to rule out any fraud and abuse activity, they are looking closely at the practice of duplicate billing. Refer to CMS MLN Matters for details.

If you are trying to reconcile a check received with the member’s account, you may search by THP’s check number. You may also sort by voucher date, voucher title or tax ID under “Sort Method.” Search by a particular date, date range or leave the default dates of 30 days prior to the current date. For the fastest search method, select your tax ID number under “Provider.” Once you have chosen the appropriate criteria, click “Submit.”

Click on the voucher date that you wish to view. The voucher date is in year, month, day format and the most current is listed last. Vouchers are divided into three sections by line of business:

- Paid Claims
- Denied Claims
- Claims in Process

This is a great tool to reconcile with your aging claims report. If your claim does not appear as either paid, denied or in-process then THP has not received your claim, so please submit it as a new claim. You may save vouchers as a PDF and print.

Claim numbers are 12 digits long. THP utilizes the Julian Calendar in numbering claims. A simple internet search will result in various websites offering Julian Calendars. We also have them available online in our provider procedural manual, section 14.

By reviewing the “Claims In Process” section of your payment voucher, you can determine the age of your claims. Because all claims submitted to and received by THP are paid within 30 days of receipt, you can also determine the approximate date your claims will pay or deny.

Log on to our secure provider website at healthplan.org/providers to access payment vouchers to compare to your aging claims.

Calculating Claim Age
Today’s Date: 2016176 (June 24, 2016)
Claim Date: 2016161 (June 9, 2016)
T5 Days Old

Calculating Payment/Denial Dates
2016176 (June 24, 2016)
+ 30
2016206 (July 24, 2016)
*THP pays claims within 30 days of receipt

Understanding THP Claim Numbers
Sample Claim Number: 201617621234

<table>
<thead>
<tr>
<th>Year</th>
<th>Julian Date</th>
<th>THP ID No.*</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>17621234</td>
<td>17621234</td>
</tr>
</tbody>
</table>

*THP ID No. is for THP use only.
The Health Plan Disease Management Program for COPD follows the Global Initiative for Chronic Obstructive Lung Disease (GOLD) Standards and Guidelines for educating our members about self management skills and lifestyle changes to reduce symptoms and reduce risk of disease progression and exacerbations. One of the key factors we emphasize with members is the importance of spirometry testing for the diagnosis and ongoing assessment of COPD.

GOLD guidelines state that spirometry testing is needed to make a clinical diagnosis of COPD. A normal spirometry value excludes the diagnosis of COPD. Spirometry value and presence of symptoms help gauge the severity of disease and serves as a guide for treatment.

Once the diagnosis is confirmed, periodic spirometry testing should be used to monitor disease progression. The GOLD guidelines recommend an interval of at least 12 months between measurements.

THP’s Disease Management nurses also follow-up with members after hospital or ED visits for COPD exacerbations. They ensure that the member understands his or her discharge instructions, including medications. They educate members on proper dosing and scheduling of systemic corticosteroids and bronchodilators, the GOLD recommended treatments for COPD exacerbations.

The GOLD guidelines may be accessed directly at goldcopd.org.

The Health Plan Disease Management Programs are staffed by registered nurses who will work with you and your staff to assist your patients in managing and controlling their chronic disease. Programs are available for type 1 and type 2 diabetes, gestational diabetes or other high risk pregnancy, COPD, depression, and heart failure. You can refer a patient who you feel would benefit from one of the programs by phone or website. Patients may register by phone or via The Health Plan website as well. Nurses will contact the member periodically by phone to assess his or her self management activities and provide education and support.

**Spirometry Testing & COPD**

**Member Rights and Responsibilities**

We would like to remind all provider offices that the member rights and responsibilities can be found in the Provider Procedural Manual, Section 3. If you would like a copy please contact Provider Relations Customer Service at 740.695.7901 or 1.800.624.6961, ext. 7901.

**REMEMBER:**

CMS Annual Training Requirements

CMS requires documentation from our providers of the completion of the compliance training in FWA on an annual basis. This will assist in meeting the regulatory requirement for training and education. The FWA training is a requirement of the Social Security Act, CMS, Office of Inspector General (OIG), and HIPAA privacy regulations, as well as state Medicaid programs.

- The training must be completed within 90 days of the initial hire or the effective date of contracting and at least annually thereafter.

- You are required to maintain evidence of training for 10 years; this may be in the form of attestations, training logs or other means determined by you to best represent completion of your obligations.


**Requesting Medical Records**

By simply using the following codes, this may keep one of our QI staff from contacting you for medical records. This information is needed to satisfy HEDIS measures:

- BMI: Category II code 3008F or ICD-10 Z68.2
- Diet Counseling: Z71.3
- Physical Activity Counseling: Category II- 4019F; HCPCS: G0447
On October 30, 2015, the Centers for Medicare and Medicaid Services (CMS) unveiled the 2016 Medicare Physician Fee Schedule (the “Final Rule”), which outlined some changes to the Physician Self-Referral “Stark” Law, Statute (42 U.S.C. § 1395nn), that generally prohibits physician referrals for designated health-related services payable by Medicare or Medicaid to an entity with which the physician (or an immediate family member) has a financial relationship, unless there is an exception. The law does not require any showing of the “wrongdoer’s” intent however.

The purpose of this Final Rule is to enhance compliance, and accommodate the healthcare payment system reform, through the issuance of new exceptions to the Stark Law. These new regulations became effective on January 1, 2016, with the exception of the definition of “ownership or investment interest” as it relates to the level of physician ownership in physician-owned hospitals, which is slated to become effective on January 1, 2017.

One of the “exceptions” revolves around “timeshare” arrangements, where a hospital or local physician practice may arrange with a specialist from another community to provide services in a space that is owned by a hospital or practice on a limited or as-needed basis. These arrangements would involve the use of another person’s or entity’s premises, equipment, personnel, items, supplies or physician services under a license rather than under a traditional lease. Additional information on this arrangement can be located at 42 C.F.R. § 411.357(y).

The second exception permits remuneration from a hospital, rural health clinic (RHC), or federally-qualified health center (FQHC) to a physician in order to assist the physician in employing a non-physician provider in the geographic area served by the hospital, RHC or FQHC. More information on the requirements of this new exception can be found under 42 C.F.R. § 411.357(x).

In addition to these two added exceptions, the Final Rule also addresses such topics as writing requirements, term and signature requirements, holdover arrangements, and defines “remuneration” under the Stark Law, and what constitutes the geographic areas served by RHCs and FQHCs.

Ultimately, CMS believes that these changes and enhancements to the Stark Law should provide healthcare practitioners with more flexibility with certain business arrangements.

*** Please note that fraud waste and abuse (FWA) training must be completed within 90 days of initial hire for all employees and contractors, and annually thereafter. As of 2016, this must be completed through CMS’s Medicare Learning Network (MLN) at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html.

See also (42 C.F.R. §§ 422.503(b)(4)(vi)(C)(3) and 423.504(b)(4)(vi)(C)(4)).

For additional guidance on FDR responsibilities when conducting business on behalf of The Health Plan and its members, please refer to The Health Plan Standards of Conduct for FDRs, which can be accessed through our website under Providers, Support & Service, Compliance, Fraud Waste and Abuse.
Molecular Pathology Pre-authorization Reminder

Genetic Testing

Genetic, genomic, pharmacogenetic and pharmacodynamic testing services remain on The Health Plan’s list of services requiring preauthorization and medical review. Genetic testing and molecular pathology tests may be medically necessary in members who display certain clinical features or are at risk of inheriting a particular mutation when the test results will directly impact the treatment planned and delivered to a member. Documentation of a comprehensive clinical exam and results of conventional diagnostic studies should be submitted for review when requesting pre-authorization, along with supportive information that the provider has educated the member and/or family regarding the test and its implications and offered genetic counseling when appropriate as part of the informed consent process. Testing should always be performed utilizing participating laboratory providers when available. Please visit The Health Plan website and search “Find a Provider” for participating lab providers or call Customer Service for assistance with questions.

Coding Your Experience

Patient non-compliance and their medications

ICD-10 codes starting at Z91.1 will paint the picture of patient non-compliance with medications. This could protect you. A large quantity of research concerning issues of patient compliance with medications has been produced in recent years. The assumption in much of this work is that patients have little option but to comply with the advice and instructions they receive. Studies have shown, however, that between one-third and one-half of all patients are non-compliant.

Many times the patient weighs the cost/risks of each treatment against the benefits as they perceive them. Their perceptions and the personal and social circumstances within which they live are shown to be crucial to their decision making. The apparent irrational act of non-compliance from the doctor’s point of view may be a very rational action when seen from the patient’s point of view. One solution is to develop a more open, cooperative doctor-patient relationship.

Behavioral Health Codes No Longer Covered

Medicaid Behavioral Health Codes

Effective February 1, 2016, there have been some updates to the Medicaid Behavioral Health Provider Manual. CPT codes 90838 and 90785 will no longer be covered codes.

Targeted case management coverage has been updated as well as The Health Plan’s standard, four units covered per month without need for documentation. However, beginning February 1, 2016, up to 36 units over a three-month period may be pre-authorized. These units do require documentation. The requirements are listed in the provider manual.
In 2015 there were 598 opiate-related fatal overdoses in West Virginia. Recently the state of West Virginia’s Attorney General’s Office and the state Board of Pharmacy announced a joint venture to supply providers in the state of West Virginia with a morphine equivalency calculator. Previously morphine equivalence was calculated using the following formula:

\[
\text{Opiate mg x Medication Number per Day x Conversion Factor} = \text{MEq per Day}
\]

Conversion factors had to be referenced using cumbersome charts such as the one below.

<table>
<thead>
<tr>
<th>Opiate Ingredient</th>
<th>Conversion Factor</th>
<th>Example (Opiate mg x # per day x Conversion Factor =)</th>
<th>MEq Per Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codeine</td>
<td>0.15</td>
<td>30mg tab x 3 per day = 30 x 3 x 0.15 =</td>
<td>13.5</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>100</td>
<td>50mcg patch: 0.050mg/hr patch x 24 hr = 0.05 x 24 x 100 =</td>
<td>120</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>1</td>
<td>7.5mg tab x 4 per day = 7.5 x 4 x 1 =</td>
<td>30</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>4</td>
<td>8mg tab x 6 per day = 8 x 6 x 4 =</td>
<td>192</td>
</tr>
<tr>
<td>Methadone</td>
<td>3</td>
<td>10mg tab x 2 per day = 10 x 2 x 3 =</td>
<td>60</td>
</tr>
<tr>
<td>Morphine</td>
<td>1</td>
<td>60mg tab x 3 per day = 60 x 3 x 1 =</td>
<td>180</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>1.5</td>
<td>5mg tab x 6 per day = 5 x 6 x 1.5 =</td>
<td>45</td>
</tr>
<tr>
<td>Oxymorphone</td>
<td>3</td>
<td>20mg tab x 2 per day = 20 x 2 x 3 =</td>
<td>120</td>
</tr>
<tr>
<td>Buprenorphine</td>
<td>10</td>
<td>8mg film x 2 per day = 8 x 2 x 10 =</td>
<td>160</td>
</tr>
</tbody>
</table>

The new morphine equivalency calculator will be part of the Board of Pharmacy’s website. The calculator will help augment the Controlled Substance Monitoring Program which tracks all Schedule II-V controlled substance prescriptions filled in the state for individual patients. Data and information from the Centers for Disease Control and Prevention will be used in the design of the calculator.

The Health Plan Dual-Eligible Plan Training

Annual D-SNP Provider Training

The Health Plan offers a Medicare Advantage Dual Eligible Special Needs Program (D-SNP) in West Virginia and Ohio. The D-SNP program targets special populations individuals who are entitled to Medicare and are also eligible for some level of assistance from their state Medicaid program. Their services are coordinated so that the member obtains the maximum benefits of their dual coverage.

The Health Plan’s provider website offers a training slide presentation to further explain the program and features of the navigation process. We encourage you to visit our website under Providers, Support & Service, Compliance Fraud, Waste and Abuse.

Once you have reviewed the training, please complete the attestation form and submit to our Provider Network Service Department.
Research shows that 40 to 80 percent of medical information is forgotten immediately. Of retained information, 50 percent is remembered incorrectly. This statistic is especially important for telephonic case management. Use of the “Teach Back” method of conversation confirms that the teacher has provided the essential information in a manner understandable to the patient.

Examples:

“I want to make sure I explained your medication correctly. Can you tell me how you are going to take the _____?”

“I gave you a lot of information about diabetes. Can you tell me three things you are going to do today to improve control of your diabetes?”

When discussing medications, be aware if your patient:

- Demonstrates limited English language proficiency or low literacy
- Has a history of mental health issues like depression, anxiety or addiction
- Doesn’t believe in the benefits of treatment
- Believes medications are unnecessary or harmful
- Has a concern about side effects
- Expresses concern over the cost
- Says he or she is tired of taking medications

Introducing Epocrates

The Health Plan has recently partnered with Epocrates, a mobile software company which enables on-demand, easy access to up-to-date formulary information. This software allows providers to save time by reducing pharmacy call backs. This will help to improve patient care, safety and satisfaction by allowing you to check prior authorization requirements, copay tiers, alternatives and generic substitutions, quantity limits and coverage for THP plans. For more information on how to download/access this software via the web or mobile app visit: https://www.healthplan.org/providers.

THP’s Affirmative Statement Regarding Incentives August 2016

The Health Plan bases its decision making for coverage of health care services on medical appropriateness utilizing nationally recognized criteria. Incentives are not offered to providers or The Health Plan employees involved in the review process for issuing non-authorization, nor does The Health Plan specifically reward, hire, promote, or terminate practitioners or other individuals for issuing denials of coverage.

Also, no incentives are given that foster inappropriate under-utilization by the provider, nor does The Health Plan condone under-utilization, or inappropriate restrictions of health care services.

RENDER Signatures, Credentials and Dates Are Important

Each entry in the patient’s medical record requires the acceptable signature, including credentials and the date of the person writing the note.
How Does a Provider Impact Star Ratings?

Keys to improving patient’s quality of care

Provider performance impacts nearly two-thirds of the Star measures and includes member surveys of provider performance. The following is a sample of some items for which CMS measures provider performance:

**Appropriate Medical Care**
- Receiving required tests, screenings and vaccines
- Discussing exercise, physical activity and mental health issues
- Discussing fall risk management interventions for members who fell or had balance issues in the last six months
- Discussing and treating members with urine leakage problems
- Measuring and recording BMI

**Prescription Drug Management**
- Were prescription medications discussed, and are patients taking their medications as prescribed?
- Are providers prescribing certain high-risk drugs with serious side effects when there may be safer drug choices?

**Patient Experience**
- How easy was it for patients to get an appointment?
- How long are wait times and did they receive timely care?
- Was the patient treated with courtesy and respect?

**Care Coordination**
- Did the provider have medical records and other information about the member’s care?
- Did the provider share test results timely?
- Did the provider assist in managing member’s care including specialist care?

Fraud Alert

**Compounded Pain Cream Scams**

Please be alert to one of the most current and costly scams being conducted to date. Pharmacies that are marketing a variety of compounded creams place calls to members/patients offering the pain cream and inquiring if they may contact their physician to discuss it. The pharmacy will fax or send a pre-filled in form to the physician office requesting signature. The pharmacy then submits a claim for these creams, typically at a grossly inflated cost. In some instances they bill for literally thousands to tens of thousands of dollars for small quantities of the cream; if it is sent out to the patient at all. In many cases, these creams contain medications that in whole or part are not FDA approved or not approved for topical use. In other instances, the creams do not even contain the substances the pharmacy is billing for.

**WHAT YOU CAN DO TO HELP:**

Please be alert to these scams and be cautious of what you are signing. Be sure that these creams, supplies or various types of equipment are truly needed for your patients. Remember, by signing the form, you could be putting yourself at risk as well.

Make sure your patients know what you think they need in terms of supplies, equipment, and treatment. Often educated members are proving to be the front line for discovery of these scams.