ProviderFocus
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Notice of Changes to Prior Authorization Requirements

Effective March 15, 2017, the following changes will be made to The Health Plan's pre-authorization/pre-notification requirements:

Additions:

- **Total joint arthroplasty performed in ambulatory surgical center**
- **Balloon sinuplasty**

Pre-authorization notice of changes, lists and forms can be found at healthplan.org/preauth.

Inside this issue …

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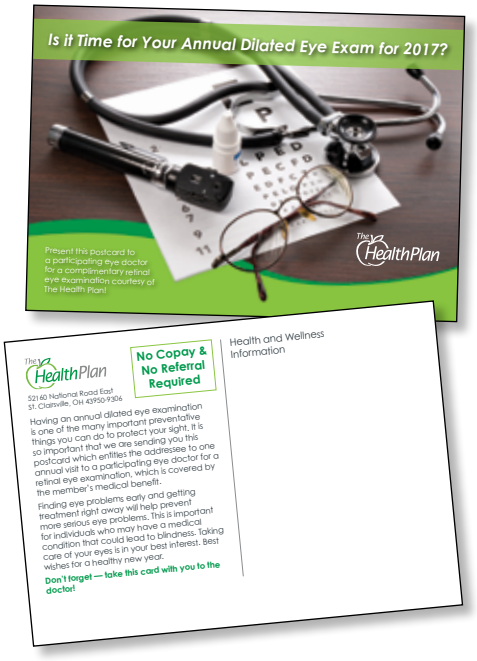
Retinal eye exam coupons

New Year, New Look

The importance of an annual dilated retinal eye exam for people with diabetes is undisputed. Despite the evidence to support this, many people with diabetes still fail to get their annual eye exam. At The Health Plan, we have adopted a coupon program to encourage our members with diabetes to get this very important exam annually. For many years, we have provided our Commercial, Medicaid, and Medicare members with a coupon that waves their copay for the diabetes eye exam. The paper coupon which we previously sent attached to a letter has been replaced with a new, updated look that will come to the member in a postcard format. The member will present the postcard to you, the provider, to remind you to submit a dilated fundus report with the visit claim in order to be reimbursed the copay from The Health Plan. If the member has lost his or her postcard, you can still submit fundus report with the claim for reimbursement. A customer service representative can verify member eligibility if there is a question. An example of the postcard is above, so be on the lookout for these in your office. As always, diabetes nurse educators are available at THP to assist your members with diabetes care and self management education, and diabetes resources are available online at healthplan.org.



Specialty Pharmacy 2017

Trending to the future

The Health Plan Pharmacy Services, operating as THP Rx, has developed a new specialty pharmacy network! This new program, which began January 1, allows The Health Plan to maximize patient safety and enhance patient management for obtaining best outcomes.

THP Rx partners only with URAC-accredited specialty pharmacies. These include Allied Health Solutions, Med Center Specialty Pharmacy, NuFactor for IVIG, Onco360 for oncology, and others. Upon the notification of approval, THP Rx will indicate the specialty pharmacy and contact information to whom you can send the prescription.

Prior authorization forms for specialty medications can be found on The Health Plan's website under the Provider section. You may fax prior authorization requests to 740.695.5297 or 1.888.329.8471 Attn: Pharmacy Department. If you have any questions or need to contact us regarding specialty medication requests, please call 740.695.7914, option 4.

Medicare Supplement Plans

Medicare Crossover

Effective as of August 29, 2016, for Medicare Supplement Plans only, when your patient presents this ID card from The Health Plan, you will no longer have to submit a claim to The Health Plan after Medicare pays.

Medicare will send us your claim information and we will then process for the remaining copayment, co-insurance, or deductible.

As a reminder, this plan will only cover those services that have been paid by Medicare. If Medicare denies the service, The Health Plan will also deny your claim.

If, in the future, The Health Plan decides to do Medicare crossover claims for other lines of business, we will notify you at that time.

Important Dual-Eligible Billing

Billing and compliance with accepting the dual eligible member (D SNP)

Federal law prohibits Medicare providers from collecting Medicare Part A and Medicare Part B deductibles, coinsurance, or copayments from those enrolled in the dual-eligible program. This program exempts individuals from Medicare cost-sharing liability. Medicare providers must accept the Medicare payment and Medicaid payment (if any) as payment in full for services rendered to an eligible member. Providers who bill a qualified dual eligible member for amounts above the Medicare and Medicaid payments (even when Medicaid pays nothing) are subject to sanctions. See Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the Balanced Budget Act of 1997. This section of the Act is available at ssa.gov/OP_Home/ssact/title19/1902.htm

Providers may not discriminate by refusing to serve enrollees because they receive assistance with Medicare cost-sharing from a State Medicaid program.

Transitioning to electronic transactions

Savings Calculator

The CAQH Index is tracking and measuring the transition from paper- and phone-based to electronic-based administrative transactions. Organizations that are conducting electronic administrative transactions are reducing time-consuming manual processes and eliminating waste, thereby simplifying healthcare administration.

Health plans and providers may use the interactive calculator located at caqh.org/explorations/savings-calculator to input manual transaction volumes. This calculator will estimate potential organizational cost savings that may be achieved by processing claims and other associated transactions electronically. The calculator results will display cost savings related to converting entirely (100 percent) or partially (50, 25, and 10 percent) to electronic processing for each transaction.

Before getting started with the calculator, you will want to identify one or more of the following transaction volumes being processed manually by your organization:

- Claim Submission
- Eligibility Verification
- Prior Authorization
- Claim Status
- Claim Payment
- Remittance Advice

Notices

- **Effective January 18, 2017, The Health Plan switched from weekly to bi-weekly payments under our Provider Agreement with you. Pursuant to the amendments section of our agreement, The Health Plan hereby amends the billing procedure attachment, of our agreement to provide for such bi-weekly payments.**

  As always please feel free to contact Provider Services at 1.877.847.7901 if you have any questions regarding this amendment to our Agreement.

- **Effective January 1, 2017, The Health Plan's Medicaid line of business will be adopting BMS' Drug Screening Policy. Providers can locate the most current policy, guidelines, and limits on the BMS website: dhhr.wv.gov/bms/Pages/Chapter-529-Laboratory-Services.aspx**

- **The Behavioral Health Services Department has added a unit to address the needs of our new SSI members. Requests for pre-authorization of services or utilization review information should be submitted in the same manner as information is submitted presently. Telephonic requests or information submission should be called to 740.699.6987.**

- **Please be sure to use ICD-10 codes when submitting Medicare supplemental claims. Also, please be aware of the correct placement of your NPI on the 1500 form.**

- **A few items regarding anesthesia claims:**
  It is necessary to only bill time units in the unit field for claims to be paid correctly.
  Physical status modifiers are required on all MAC anesthesia claims in order to receive the appropriate payment.

Improving accuracy

Submission of Paper Claims

The Health Plan scans paper claims using a Kodak optical scanner that only reads red and white paper claims. The scanner takes the red out and then loads all the information from the claim into our system.

These Kodak optical scanners cannot read black and white claims; therefore, we are urging all providers to submit their claims on red and white forms only. This also means that red and white paper claims can't be faxed to The Health Plan unless you can fax in color. (You can find red and white HCFA 1500 forms at your local office suppy stores.)

Submitting your paper claim to us on a red and white form ensures your claim gets loaded into our system accurately, with less manual keying that may cause an error to occur.

As a convenience to you, you have the ability to submit your claim to us electronically through our secure web portal. You can also use any of our approved clearing houses to submit your claims, if you prefer to do that instead of sending paper claims.

If faxing in for a referral, please send all referral request to fax 740.699.6163. This fax line is worked by the referral intake representative who adds your referrals. Faxing your request to another fax line will only delay the referral process.

We appreciate your assistance in this matter.

Compliance Programs for Physicians

Transitioning to electronic transactions

Establishing and following a compliance program will help physicians avoid fraudulent activities and ensure they are submitting true and accurate claims. The following seven components provide a solid basis upon which a physician practice can create a voluntary compliance program:

1. Conduct internal monitoring and auditing.
2. Implement compliance and practice standards.
3. Designate a compliance officer or contact.
4. Conduct appropriate training and education.
5. Respond appropriately to detected offenses and develop corrective action.
6. Develop open lines of communication with employees.
7. Enforce disciplinary standards through well-publicized guidelines.

With the passage of the Affordable Care Act, physicians who treat Medicare beneficiaries will be required to establish a compliance program.

For more information on compliance programs for physicians, refer to the OIG's "Compliance Program Guidance for Individual and Small Group Physician Practices" available at oig.hhs.gov/authorities/docs/physician.pdf.

Source: *Centers for Medicare & Medicaid Services, Medicare Learning Network, Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians, (March 2012),10.*

Year in review

2016 Practitioner Experience Survey

There were 974 practitioner experience surveys mailed to primary care physicians, behavioral health practitioners and secondary care physicians in 2016. We received 123 responses for a return rate of 12.6 percent which was a 3.3 percent increase over 2015. The return rate remains low.

The survey is conducted to identify areas that we can improve in Medical Management. The results are analyzed and compared to the prior year.

All questions regarding referrals, criteria, medical director, care/complex case navigation and chronic disease navigation were above the 90 percent benchmark and remain consistent.

Provider education is provided through seminars, newsletters and the website on various Medical Management programs, contact with medical directors for case discussion, pre-authorization and new technology reviews.

You may call the Medical Management Department for any issues or with questions at 1.800.624.6961, ext. 7644 or 7643, or Behavioral Health Services at 1.877.221.9295.

Notice to Medicaid Providers

HealthCheck/EPSDT reminder lists no longer need be returned

Effective second quarter 2017, The Health Plan will no longer ask our providers to return the monthly HealthCheck/EPSDT reminder list to the Outreach Department. We will continue to monitor that members are getting appropriate EPSDT services via the encounter system and report the results to WV Medicaid. As our provider, we appreciate that you monitor your patients for this important regular well exam according to the periodicity schedule.

Please be sure to continue to complete all the required EPSDT screening components for each Medicaid child/adolescent under the age of 21, and bill THP appropriately for rendered services. You will notice a different cover letter once we make this change. We will continue to send reminders to you and to our members each month, but this change will eliminate the time consuming task of you responding back to THP each month.

Improving payment times

Durable Medical Equipment

In order to assure accurate payment of DME claims, please refer to the DME Fee Schedule at healthplan.org/providers/healthlibrary/durable-medical-equipment. You will find information regarding specific requirements for HCPCS codes for each line of business regarding pre-authorizations, limits and exclusions.

As a reminder, all Medicare plans require authorizations for oxygen and CPAP rentals.

Also, for the applicable A and E HCPCS codes, the appropriate modifiers must be used to designate rental or purchase of the equipment.

By doing these few things, your claims can be paid with better accuracy and in a timely manner.

Quality Improvement Goals

Accessibility

The goal of the Quality Improvement Department is to improve medical outcomes and quality of service to our members. In order to identify issues, we routinely monitor inpatient and outpatient visits for any adverse events such as falls, post-op complications, unanticipated deaths, and re-admissions within 24 hours. We also track PCP changes, which occur when a member chooses another physician to provide their care.

Reasons often given for this change are after-hours accessibility issues, dissatisfaction with medical management, communication issues, and issues related to the physician office staff. If you or your patients have any questions or concerns about the care or service that they receive, we encourage you to call the Customer Service Department at 1.888.847.7902, or visit our website at healthplan.org.

Member survey results

Survey Says...

The results for the annual CAHPS member satisfaction surveys are in for The Health Plan's Commercial and Medicaid products. The overall ratings and composite scores are shown in the table. Items in the table marked with an asterisk indicate that the rate is below the national average. The Health Plan is committed to providing high quality care to our members and has chosen several areas to focus improvement efforts on as a result of the survey results. Among our highest priorities are the rating of "Specialist Seen Most Often" and "Getting Needed Care." Surveys will be mailed to members to gather more information regarding the care they receive from their specialists.

	Adult Commercial	Adult Medicaid	Child Medicaid
Response Rate	36.2%	21.1%	28.4%
Overall Ratings			
The Health Plan	69.5%	73.1%*	84.2%
All Health Care	77.4%	70.8%*	85.8%
Personal Doctor	83.4%	77.1%*	88.6%
Specialist Seen Most Often	83.3%*	71.4%*	75.2%*
Composite Scores			
Getting Needed Care	89.2%	81.4%*	89.2%
Getting Care Quickly	86.8%	79.4%*	95.7%
How Well Doctors Communicate	95.4%	91.8%	95.8%
Customer Service	92.7%	87.5%	94.4%
Claims Processing	95.4%	N/A	N/A
Shared Decision Making	81.2%	85.1%	77.8%
Plan Information on Costs	69.6%*	N/A	N/A

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. This manual is available on our website, healthplan.org. If you would like a copy please contact Provider Relations Customer Service at 740.695.7901 or 1.800.624.6961, ext. 7901.

Medical Management

Review Criteria

Nationally recognized clinical criteria are utilized to perform reviews for medical appropriateness. This allows for consideration of the needs of the individual member, their circumstances, medical history and availability of care and services within The Heath Plan network. Input is sought annually or as needed 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; surgical and radiological procedures including, but not limited to, MRI, MRA, CT Scan, hysterectomy, and ECT; and psychological testing.

You may call The Health Plan Medical Department at 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 urgent so 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.

Insulin Pump Supply

Updated ordering procedures

Insulin pump supplies can now be ordered on a 90-day basis. No pre-authorization is needed for ongoing supply orders. Pre-authorization is still needed for a new pump or first-time orders for members new to THP. Members may get up to 60 infusion sets and reservoirs every 90 days. Quantities above that will still need a prior authorization. An A1c test result is no longer needed if claims data is available to support that the test has been completed.

REMINDER: CMS Annual Training Requirements

CMS requires documentation from our providers of the completion of the fraud, waste and abuse (FWA) compliance training 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; this may be in the form of attestations, training logs or other means determined by you to best represent completion of your obligations.**

To view the training module for FWA go to CMS MLN at: cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Waste_Abuse-Training_12_13_11.zip.

REMINDER: 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.

Continuity is key

Coordination of Care

The goal of continuity and coordination of care is the seamless transition of patient care from one setting to another. It includes all aspects of a member's care and all of the providers involved in that care. The PCP is the most appropriate connector. A member's communication with a PCP will enhance overall health and enable the PCP to direct care so that all appropriate medical providers are involved. We encourage our members to keep their PCP informed of any change in their medical condition including visits to a specialist, inpatient or outpatient center, emergency room or urgent care facility, VA clinic, health fair, mental health care provider or other facility (intermediate, skilled or rehab). Members should inform their PCP of any tests, medications, or recommended treatments.

We also strongly encourage specialists to mail or fax medical updates to the PCP for inclusion in the member's chart. If your office has not received these reports, we encourage you and your staff to contact these entities and to include the information in the patient's medical record.

For improved continuity and coordination of care, we suggest the following:

- Phone consultation or conference calls when multiple doctors are involved in the member's care.
- Concise documentation in the medical record to show that PCP/specialist consultation has occurred.
- Mail or fax medical updates to the PCP and other specialists involved in the patient's care.

Our behavioral health providers are encouraged to discuss with their patients the importance of sharing their behavioral health care issues with their PCP. A release form is available by calling Behavioral Health Services at 1.800.624.6961, ext. 7301.

The HealthPlan

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