When review determinations are disputed or confusing for the attending physician, one available option is sometimes overlooked: A call to the medical director requesting clarification. It is a firm policy of The Health Plan that a medical director will always be available during business hours to discuss such rulings and the reasons behind them. Ordinarily, the conversation needs to take place between two physicians rather than be transmitted through third parties in either office. Frequently, a determination will change because of new information imparted during a conversation between the two physicians, but this is usually not possible when intermediaries are involved.

The standard appeal mechanisms will always be available, but sometimes a prompt resolution can be achieved in this manner without going through more elaborate procedures. When physicians make such an inquiry, having the patient’s complete name, referral number and ID number available will enable the medical director to access the electronic record at the outset of the call and in most cases resolve the issue or completely answer questions during the initial conversation. It is not mandatory to have this information in order to initiate a discussion, but without a number to identify the ruling in question the medical director may have to call back after the patient’s record has been identified in the computer files.

Claims and eligibility issues are usually more quickly handled by the Claims Department or the Customer Service Department, but we will help whenever we can.

You may reach the medical director at The Health Plan by calling 740.695.7643 or 7644 or by calling 1.800.624.6961, ext. 7643 or 7644.
Are You Properly Screening?
Fraud, waste and abuse

Federal law prohibits payment by a Medicare, Medicaid or any other federal health care program for an item or service furnished by a person or entity who is excluded from participating in these federal programs. Therefore, The Health Plan and its First Tier, Downstream and Related Entities (FDRs) are also prohibited from contracting with, or doing business with any person or entity that is excluded from participating in any of these programs.

Medicare regulations and CMS rules clearly define that providers who contract with The Health Plan to furnish health care services to our members are designated as “First Tier Entities.” (See 42 C.F.R. 422.500 & 423.501). A chart is also provided in Section 40, Chapter 9/21 of the CMS Manual which indicates that entities providing health services and hospital groups are considered first tier entities.

Each first tier entity must perform a check to confirm that its employees (permanent, temporary, volunteers and governing bodies) and downstream entities performing administrative or health care services for The Health Plan’s Medicare lines of business are not excluded from participation in federally-funded health care programs according to the OIG, SAM exclusion list screening. This check must be conducted prior to hire and/or contract and monthly thereafter. You must also maintain evidence of checks of these exclusion lists (i.e., logs or records) to document that each employee and downstream entity has been queried through the exclusion lists in accordance with current laws, regulations and CMS requirements. Exclusion list requirements can be found in 1662(e)(1)(B) of the Social Security Act, 42 C.F.R. 422.503(b)(4)(vi)(F), 422.752(a)(8), 423.504(b)(4)(vi)(F), 423.752 (a)(6), 1001.1901, and the CMS Care Manuals, Chapters 9 and 21.
The Office of the Inspector General (OIG) list of excluded individuals and entities can be found at: http://oig.hhs.gov/exclusions/index.asp.

The General Services Administration (GSA) Systems for Award Management (SAM) can be found at: https://www.sam.gov/portal/SAM/#1.

In the event that any of your employees or downstream entities is found on either of these exclusion lists, you must immediately remove that individual or entity from the work related directly or indirectly to The Health Plan’s Medicare program, and notify The Health Plan of your findings.

Also, as a general reminder, please remember 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 at: https://www.healthplan.org/sites/default/files/documents/resources/fraud-waste-abuse/FDR.pdf.

2015 Practitioner Surveys

The annual Practitioner Satisfaction Survey will be mailed out soon. The survey mailing will include behavioral health practitioners and secondary care physicians, along with all primary care physicians.

Please take the time to complete this survey so our Medical Management Department can benefit from your opinion and suggestions to better serve you.

Your name will be on the survey tool as it has the past few years. It is our intent to be better able to follow-up on your complaints, concerns or issues when your name is on the form.

Any questions, please feel free to call the Medical Management Department at 740.695.3585 or 1.800.624.6961, ext. 7644 or 7643.
Creating a welcoming environment

Improving Care Through Kindness

The beginning of a new year is an ideal time to scrutinize your practice’s image. One place to start is at your front door. What does a patient experience when he or she arrives? A first impression is an opportunity that never repeats itself. Are you doing all you can to give your patients the most positive first impression possible? Here are 10 tips that can make a big difference in your practice.

1. **Hire the kindest, most sincere person you can find as your receptionist.**
   The receptionist’s attitude has a lot to do with how a patient experiences a medical visit. In studies, it has been discovered that no matter what the patient’s encounter with the physician and nurse was like, it was the encounter with the receptionist that was most important to satisfaction. Improving that experience improved satisfaction ratings dramatically. So hire the smile and teach the skills for this position. Also, try not to overload this individual. Assigning too many duties to a receptionist can interfere with making patients feel welcome and comfortable.

2. **Respect patient confidentiality.**
   Patients should not have to state the reason for their visit when other people are present. Avoid sign-in sheets, especially the kind that ask for the patient’s chief complaint. An alternative is to have numbered pads printed. The patient signs the top sheet, tears it off and gives it to your receptionist. The receptionist can then use this information in whatever way the sign-in sheets were used (e.g., to keep track of how many patients are seen, order of arrival, etc.).

3. **Make sure your reception area is spotless.**
   Cleanliness in the reception area is extremely important. People seek to confirm their first impressions. If the reception area furnishings are stained, patients will be checking to see if your examination room equipment is dirty, too.

4. **Monitor your reception area materials.**
   Airlines don’t run movies that involve plane crashes, and you should think twice about displaying magazines with headlines such as “How I Made Millions Suing Doctors for Malpractice.” Also keep in mind that the tremendous amount of medical information in consumer magazines creates expectations for patients. For example, the October 1996 issue of Good Housekeeping contained an article titled, “Breast Exam: Is Your Doctor Doing It Right?” A patient who read that article while waiting for you to do a breast exam might have wondered about your competence if you didn’t do the exam exactly as described in the article. Being familiar with such articles can also alert you to increased concerns about certain procedures or medications.

5. **Consider the impressions that signs in your office create.**
   Do the majority of your signs pertain to insurance and billing rather than helping the patient feel comfortable? An example of a helpful sign would be one that says, “Please see our receptionist when you arrive.” A sign that reads, “Patients are seen in order of appointment, not arrival,” can ease tensions in a crowded reception area. Discourage staff from posting flip or inappropriate sayings in prominent places. A sign that says, “The worst day at the beach is better than the best day at work,” may relieve staff tensions but should be kept out of public view.
6. Be the first to say hello.
Everyone in the practice should take the initiative in greeting patients. Don’t wait for the patient to speak, because some patients will interpret your silence as indifference. Use the patient’s name whenever possible. Asking staff to review the schedule at the beginning of the day makes it easier for everyone to remember names. Also keep in mind that, while having staff members wear name tags encourages patients to ask the appropriate person for information and assistance, tags are not a substitute for a personal introduction.

7. Be prepared for the patient.
Always review the patient’s chart before entering the exam room. Your ability to know and remember information will impress patients. Social information, such as a spouse’s first name, can help you make the personal connections that are important to many patients. One physician has discovered an effective way to start every visit. He makes a note of the last thing the patient says as he or she is leaving a visit. Glancing at the chart just before the next visit, he can recall that topic of conversation and introduce it at the start of the visit. “Did your daughter’s team win the state championship?” This strategy makes each patient feel important. If a patient has been referred to you by another physician, saying something like, “Dr. Smith and I spoke about you and she told me that...” reassures the patient that his or her care is being coordinated.

Does this sound artificial to you? If so, think about this: You do care about your patients, right? But unless your memory is better than most, you won’t be able to show your patients that you care if you don’t give yourself some memory aids like these. There’s only one of you, and there are hundreds of patients.

8. Put the patient at ease.
Be alert to factors that might hinder physician-patient communication. One patient decided to look for another physician because his physician had a habit of talking with his back turned. Another patient opted not to return to a physician who greeted and examined her wearing a surgical mask. The physician never explained why he was wearing the mask, and the patient never asked.

Every member of your practice should use this strategy. When your receptionist asks about insurance first, before asking how the patient is feeling, an impression is created that you care more about the patient’s insurance than his or her well-being. Early in the visit, find out what issue is on your patient’s mind. It may not be the most significant problem clinically, but when you address this concern first, the patient can relax and concentrate on what you have to say.

10. Create a favorable impression in 60 seconds.
The amount of time a physician spends with a patient contributes significantly to the patient’s satisfaction with an office visit. In a busy practice, it’s not always possible to dedicate as much time to a visit as a patient may want or expect. If, however, you give a patient your undivided attention for the first 60 seconds of your encounter, you will leave the patient feeling that he or she had a meaningful interaction with you — and not feeling that the visit was too short.
Performance Survey Results
With the Medicaid behavioral health transition period ending December 31, 2015, The Health Plan conducted a behavioral health survey in January 2016 to gauge the performance of The Health Plan’s Behavioral Health Services Department. Providers who had billed The Health Plan for services provided to 10 or more members since July 1, 2015 were mailed a survey. Responses were received from comprehensive mental health centers, licensed behavioral health centers, FQHC’s, hospitals, private practitioners, health departments and rural health clinics. The Health Plan is pleased with the performance of our Behavioral Health Services Department based on the feedback received on this survey. Scoring was exceptional for the categories of “Courtesy of Staff” and “Ease of Contacting Utilization Management Staff.” An area that was identified as requiring attention was provider education. The Health Plan will be planning a seminar(s) and/or webinar(s) in the near future to address this concern. The Health Plan would like to thank all of the participants who took the time to respond.

POS Billing
Licensed behavioral health centers and comprehensive mental health centers which are licensed as facilities should bill services with a place of service 53.
If you have any questions regarding this issue, please contact The Health Plan behavioral health liaison, Roxanne Loughery

Help us help you by keeping your info up-to-date
Review of Your Practice Information
We at The Health Plan strive to provide the most updated information to our members regarding our network provider information such as: physical location, telephone number, hospital affiliations, whether the practitioner/provider is accepting new patients, and any other restrictions your practitioner may have. Confirmation of what lines of business your practice participates with is vital too. This information can all be verified by following the steps below.
Log on to our website at healthplan.org and click “Find a provider.” Take a minute to search by last name, ZIP Code, PCP or specialist and click the search button. It will bring up all practitioners with the same last name. Select your provider to see all of the current information that is in our system. If you do not have access to the Internet, simply give us a call and we will gladly review the information relative to your practice. Large groups may call us to ask for a report of all providers linked by tax number.
Please send practice changes in writing. You can fax the written notice to 740.699.6169 or by emailing this information to hpecs@healthplan.org.
Note: This notice will be generated quarterly to satisfy CMS reg. §§ 422.111 and 422.112 along with the Ohio Department of Insurance.
Help with chronic illnesses

Disease Management

We’re Here to Help

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 & type 2 diabetes, gestational diabetes, COPD, depression, and heart failure. You can refer a patient that 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 their self management activities and provide education and support.

“New” Coronary Artery Disease (CAD) Program

Beginning April 1, 2016, we announced the addition of a CAD management program as part of our chronic cardiac conditions disease management. The program follows American Heart Association guidelines for standards of care. Patients with ischemic heart disease, angina, or a recent MI can be referred to the program. Members may also self refer via phone or website registration. The chronic cardiac conditions program will continue to assist members with atrial fibrillation and congestive heart failure. Questions should be directed to the manager of the disease management programs at 1.877.236.2289, ext. 2286.

VPay Payment System

The Health Plan has commissioned an outside firm, VPay, to administer the direct deposits (effective August 1, 2015). For authorization purposes, we have forwarded the VPAY’s Electronic Funds Transfer (EFT) Agreement for completion to all of our providers.

If the VPay EFT Form is not completed and returned promptly before May 1, 2016, The Health Plan payments will be generated by a virtual credit card payment issued by VPay until the form is received.

We have sent previous notices regarding this change and this will be our final notification prior to the May 1, 2016 deadline. Please return the completed VPay EFT form to the VPay using the information on the form.

Thank you for your attention to this update. Please do not hesitate to contact Rose Sarcopski at 740.695.7649 or via email at rsarcopski@healthplan.org with additional questions.
Use of Non Par Labs
Remember the following guidelines

Provider relations would like to take this opportunity to remind you and your staff that the use of participating facilities, when at all possible, is paramount in controlling the utilization of health care costs. Also, of The Health Plan members, depending on their group benefit plan, may incur an increase in co-insurance responsibilities. The use of par facilities considerably lowers the members' portion of their possible out of pocket expenses. Finally, the use of participating laboratories is required per your physician contract with The Health Plan when services rendered are available in plan.

If you or your staff has difficulty obtaining the names of The Health Plan’s participating laboratories, please contact our Customer Service Department at 740.695.7901. Our friendly, courteous staff will be happy to assist you with a complete list of participating facilities convenient to both you and your patient. If you are having difficulty finding a participating laboratory to provide a particular service, please contact our Medical Department staff. Our Medical Department is available to assist with locating facilities providing services not available in plan. If services cannot be rendered with a par laboratory, the services must be prior authorized.