THP ProviderFocus
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Any physician or other eligible professional who prescribes Part D drugs must either enroll in the Medicare program or opt out in order to prescribe drugs to their patients with Part D prescription drug benefit plans. Medicare Part D may no longer cover drugs that are prescribed by physicians or other eligible professionals who are neither validly enrolled, nor opted out of Medicare. All prescribers should enroll before January 1, 2016 to allow for the processing of applications and to ensure enrollees get their prescriptions.

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The HealthPlan

The HealthPlan

Streamlining patient care

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 areas of the members care and all of the providers involved in that care. The primary care provider is the most vital connector. The member relies on the primary care provider for guidance in all their health care decisions, therefore knowing all specialists and other office information is key. We encourage our members to keep their primary care provider informed of any change in their medical condition including visits to; an intermediate skilled or rehab facility, an inpatient or outpatient center, emergency room or urgent care visit, VA clinic, health fair, mental health provider or any specialist as well as any testing, medications or treatments that were recommended.

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

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

- Concise documentation in the medical record to show that PCP/ specialist consultation has occurred.
- Mail or fax medical updates to the primary care provider and other specialists involved in the patient care.

For improved continuity and coordination of care for our behavioral health members, our behavioral health providers are encouraged to discuss with their patients the importance of sharing their behavioral health care issues with their primary care provider. A release form is available by calling Behavioral Health Services at 1.800.624.6961, ext. 7301.

Compliance Through Training

Staying Compliant

The Health Plan strives at being proactive by using education as a tool to ensure that our members receive the highest quality of care through you, the provider. The compliance Department at The Health Plan is thus committed to furnishing periodic reminders and updates to providers on various compliance related subjects to facilitate our preventative approach in meeting this goal.

- 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; 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.

- Another option is: CMS Fraud Waste and Abuse training: cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html; Another FWA training which meets CMS requirements outlined in 42 CFR § 422.503(b)(4)(vi)(C) and 42 CFR § 423.504(b)(4)(vi)(C) or CMS deemed FWA training through enrollment into Parts A or B of the Medicare program or accreditation durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).
- It is recommended that you verify with your outside billing or management firms that they are also including CMS FWA and compliance training as part of their seven core requirements of their compliance plan.
- We have provided attestation statements for completion of the training on our website at healthplan.org, or you may print the form, sign, date, and mail or fax the form to the Provider Relations Department at 740.699.6169.

The Health Plan maintains our provider's attestation forms for verification of education in this area in order to meet state and federal government requirements, and we will be tracking our network providers to ensure that all required training has been completed. You are required to complete the FWA training on an annual basis, and provide proof that you have completed the training along with the date(s). If you have already completed the CMS FWA and compliance annual training, please submit the sign in sheet or other proof that the training has been completed. All proof of FWA and compliance training is to be maintained for 10 years after contract termination.

For additional information or assistance, please contact the Provider Relations Department at hpecs@healthplan.org

The Health Plan
Fraud Waste & Abuse Hotline
740.699.6111 or 1.877.296.7283

Maintaining ethical standards

Compliance Week

The Health Plan will be celebrating Corporate Compliance Week November 1 - 7, 2015. This week serves as a reminder for everyone to update your compliance policies and procedures as well as your compliance plan. Please take a few moments to review our compliance plan. Visit healthplan.org then click 'Providers,' hover over 'Support & Service,' click 'Compliance, Fraud, Waste and Abuse,' 'The Health Plan Standards of Conduct for FDR' and 'The Health Plan Corporate Compliance Plan and Code of Conduct' are key documents for all employees.

Anyone can report a compliance issue or suspect activity by calling 1.877.296.7283. (This call can be anonymous.)

Information updates

Behavioral Health

Psychotherapy for Medicaid Membership
As part of The Health Plan's Behavioral Health Services for the WV Medicaid line of business, services provided by counselors/therapists are now covered. Any practitioner who would like to become a participating provider for this line of business should contact the credentialing department at The Health Plan.

Update to the Medicaid Behavioral Health Provider Manual
The Health Plan has been advised that crisis residential services are the responsibility of the state of WV. Crisis residential information has been removed from the manual. Information regarding PRTF admission and concurrent review has been added to the manual.

Medicaid Transition of Care Period Extended for Behavioral Health
The Health Plan will extend the Mountain Health Trust and West Virginia Health Bridge Transition period through December 31, 2015. This means that all existing pre-authorizations will be honored through that date.

Health Care Professional Advice To The Health Plan Members

The Health Plan does not prohibit a health care professional from advising or advocating on behalf of their patients.

This includes:

- **Providing patients with information on their health status, medical care or treatment, including alternative treatment that may be self-administered.**
- **Providing sufficient information to the patient to provide an opportunity to decide among all relevant treatment options.**
- **Discussing the risks, benefits and consequences of treatment vs. non-treatment.**
- **Providing the opportunity for the member to refuse treatment and to express preferences about future treatment decisions.**

Notes on claims processing denials

First Days of ICD-10

The first few days of ICD-10 claims processing did not bring many surprises but we wanted to present some of the most common coding errors we encountered in order to assist with the next batch of claims so as to help you prevent any further delays in processing and payment.

The highest volume of denials of claims were on the basis of the missing digits of a required code. CMS in their flier explained the requirement to have the correct family of code but not necessarily the correct code. The correct family of code requires the code used by the required number of digits.

Below are just some of the codes being denied and why:

S46.111	Strain of muscle, fascia and tendon of long head of biceps, right arm	need 7th digit
W10.0	Fall (on) (from) escalator	need 7th digit
S92.332	Displaced fracture of third metatarsal bone left foot	need 7th digit
T50.B96	Under dosing of other viral vaccines	need 7th digit
S34.8XX	Injury of other specified nerves of thorax	need 7th digit
T84.01	Broken internal joint prosthesis	need 6th digit
W21.81	Striking against or struck by football helmet	need 7th digit
O36.513	Maternal care for known or suspected placental insufficiency, third trimester	need 7th digit
T78.40	Allergy unspecified	need 7th digit
S92.301	Fracture of unspecified metatarsal bone(s)	need 7th digit
T78.00	Anaphylactic reaction due to unspecified food	need 7th digit

In the future we will try to keep you updated of any further common denials caused by coding errors as a result of the move to ICD-10.

Please do not hesitate to contact us if we can be of any assistance with ICD-10 coding.

Medication Reconciliation at Discharge

Billing tip

Codes: 99495 or 99496 should be billed for the process of medication reconciliation at the time of discharge from both acute and non acute admissions. This reconciliation is done to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions. This process is comprised of five steps: (1) develop a list of current medications within the chart; (2) develop a list of medications to be prescribed at discharge; (3) compare the medications on the two lists; (4) make clinical decisions based on the comparison; and (5) communicate the new list to appropriate caregivers and to the patient. All herbals, vitamins, supplements and OTC drugs must be considered. Transmitting the medication lists to the follow-up physician is required to satisfy this reconciliation. Billing the above codes may keep The Health Plan representatives from calling your office to supply medical records to support this measure.

CMT codes can be reported with 97140 (manual therapy)

Chiropractic Coding Reminder

Per the ACA, when CMT (chiropractic manipulative treatment codes 98940 - 98943 are billed with 97140 (manual therapy techniques) for manual therapy on the same date, modifier 59 is applied to the 97140 when the services represented by 97140 are performed on a DIFFERENT area than the CMT. Manual therapy performed on the same level as CMT would be considered incidental when performed on the same date.

72010: Radiologic examination, spine entire, survey study, anteroposterior and lateral: As a reminder, because this test involves examination of the entire spine, be sure that notes clearly support the medical necessity for the test when performed.

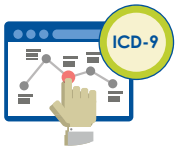
Use ICD-10 Now – Here's How

Effective Date October 1, 2015

1. Coding Claims

You must use ICD-10 on claims for services provided on or after October 1

You must use ICD-9 on claims for services provided before October 1



2. Splitting Claims

Many health plans require claims with dates of service spanning October 1 to be split into two claims:

Code services before Oct 1 with ICD-9

Code services on and after Oct 1 with ICD-10

For Medicare FFS requirements, see MLN Matters articles SE1325 and SE1408

3. Accessing Codes

Free code lists and ICD-9/ICD-10 mappings are available from CMS, vendors, and trade associations, for example:

- 2016 ICD-10-CM and GEMs (CMS)
- 2016 ICD-10-PCS and GEMs (CMS)
- CMS ICD-10 Code Lookup
- ICD-10 Code Translator (AAPC)

For more info see CMS list of ICD-10 Coding Resources

4. Free Resources

Resources to help you at no cost include:

1. Official CMS website
2. Road to 10, a CMS online tool at roadto10.org
   - See common codes, documentation tips, and clinical scenarios for your specialty
   - Build a customizable action plan

Many medical and trade associations also offer resources at low or no cost

For details, see the CMS Quick Start Guide, Road to 10, and more at cms.gov/ICD10

Special Needs Plan (D-SNP)

Medicaid and Medicare Advantage Dual Eligibility

Effective January 1, 2014 The Health Plan began administering a Medicare Dual-Eligible Special Needs Plan (D-SNP) under our Medicare Advantage Plan for members who are entitled to Medicare and are also eligible for some level of assistance from their state Medicaid program.

The Health Plan received approval as a contracted MA-PD plan that is offering a new SNP program by completing a Model of Care (MOC) for CMS. Although there are various types of special needs programs, this approval applied to the D-SNP.

Because of the complex health care needs of this population, The Health Plan has developed a specific MOC to provide comprehensive care management to members enrolled in the D-SNP. The Health Plan's MOC is a written document that describes the measurable goals of the program, along with The Health Plan staff structure and care management roles, and the use of clinical practice guidelines and protocols. The program includes both training for personnel and our providers, a health risk assessment tool to collect information on the health needs of the members as they enroll and the development of an individualized care plan for each member. Our communication efforts and care management strategies for the most vulnerable subpopulations represented in this product will be essential to ensure a performance of optimal health outcomes. Included in the measurable goals are:

- Improving access to essential services including medical, behavioral health and social services by providing a comprehensive network. SNP members will select a primary care physician and in many cases a secondary care physician appropriate to his or her clinical needs.

"...for members who are entitled to Medicare but also Medicaid eligible..."

- Streamlining the process of transition of care across health care settings, by working with our physicians and other providers.
- Improving access to preventive care as well as ongoing chronic needs.
- Improving member health outcomes as reflected through annual HEDIS data collection as well as member survey measures.
- Providing each SNP member with an assigned case manager who can assess ongoing needs and access needed social services that are appropriate.

The above measurable goals are just a brief description of some of our areas of focus for this population.

Provider Reimbursement and Billing

The provider will bill The Health Plan for medically appropriate covered services provided to the D-SNP member just as they currently do for our Medicare Advantage populations. The Health Plan will reimburse the provider for services rendered according to the member's benefit plan, less any copays coinsurance or deductible amounts. The provider will then submit any balance associated with the copays, coinsurance and deductible directly to West Virginia or Ohio Medicaid programs.

Provider Education

Provider education will be conducted by several approaches: face-to-face, web-based training, seminars and ProviderFocus newsletter articles. Additional information regarding the SNP's program and training in your region will be forthcoming.

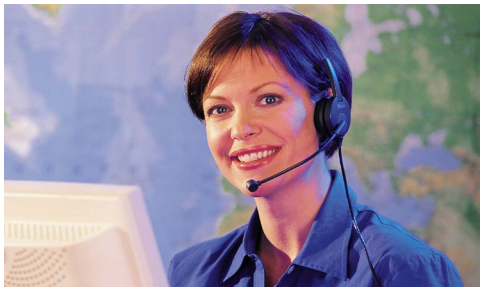
To obtain additional details for this program please review our MOC at www.healthplan.org/medicare-compliance.

Our nurses are here to help

Case Management Program

The Health Plan has registered nurses that are certified case managers to coordinate health care services for members with catastrophic illnesses, injuries or behavioral health problems. If you have a patient you believe would benefit from the case management program, you can contact the case managers by calling the Medical Department at 740.695.7644 or 740.695.7643 and toll-free at 1.800.624.6961, ext. 7644 or 7643. Contact the behavioral health unit at 1.877.221.9295.

Also, The Health Plan website healthplan.org, has detailed information regarding the case management program, behavioral health unit and even an online physician case management referral form to easily refer one of your patients.

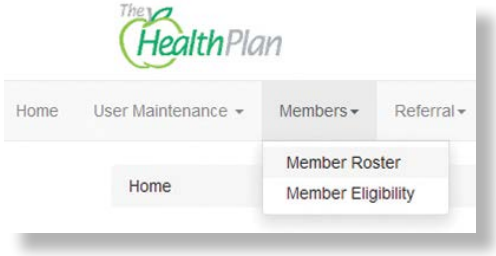


Member Rosters Obtainable

On our secure provider site

Primary care providers (PCP) such as family practice, pediatricians, and secondary care providers (SCP) such as OB GYN, nephrologists and oncologists can obtain a roster of The Health Plan members who have them selected.

To obtain the roster of members assigned to the provider, log on to healthplan.org select the providers tab and choose provider sign in, at the upper right corner of the site. Once logged in click on Members and select Member Roster in the drop down menu.



Select the PCP or SCP from the drop down and select the criteria for your roster by:

- Line of business
- Sort by name, date of birth, product line, effective dates
- Delivery type: on the screen by PDF or in a spreadsheet

Our website is updated daily in the evenings. Changes should be reflective with 24 hours.

Medicare Advantage Plans

CMS views contracted providers as extensions of the Medicare Advantage (MA) plan and CMS no longer recognizes the traditional Advance Beneficiary Notice (ABN) for MA plans (they still recognize it for traditional Medicare). If a member wants to receive a non-covered service, then either the member needs to call customer service or the provider needs to call the pre-authorization department prior to services being rendered and request an organizational determination. Both the member and provider will then receive a letter indicating the member can be billed for these non-covered services.

The only other option would be for the contracted MA provider to not bill The Health Plan for the non-covered services. Then they could bill the member directly. However, the member may 'request' the MA plan be billed prior to the member paying, and in that instance, the claim would be denied as 'not covered, bill patient."

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 the provider relations customer service representatives at 740.695.7901 or call 1.800.624.6961, ext. 7901.

Survey Says...

Member survey results

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 have 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	39.0%	21.5%	28.6%
Overall Ratings			
The Health Plan	78.3%	73.0%*	85.8%
All Health Care	80.6%	68.7%*	86.2%
Personal Doctor	86.8%	76.3%*	87.7%
Specialist Seen Most Often	83.0%*	71.1%*	83.1%*
Composite Scores			
Getting Needed Care	90.8%	77.9%*	90.2%
Getting Care Quickly	90.4%	83.5%*	94.9%
How Well Doctors Communicate	96.0%	91.2%	95.7%
Customer Service	92.5%	86.5%	92.8%
Claims Processing	95.2%	N/A	N/A
Shared Decision Making	80.7%	83.0%	78.7%
Plan Information on Costs	65.2%*	N/A	N/A

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