



# Provider Focus

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## SSI Webinar for Referral Review

If you were unable to attend the WV Supplemental Security Income (SSI) Transition webinar, you can check it out on our YouTube channel [youtube.com/watch?v=6IKxwm0D3s&feature=youtu.be](https://www.youtube.com/watch?v=6IKxwm0D3s&feature=youtu.be). Review the frequently asked questions from the webinar [healthplan.org/ssi-transition-webinar](http://healthplan.org/ssi-transition-webinar).

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## Incorrectly Addressed W-9s

# Avoiding 1099 Form Delays

The Health Plan's returned 1099 forms increased by 133 percent for the 2016 fiscal year. When 1099 forms are sent back, it can take up to two weeks to send, receive and research. As a result, a 1099 delay can also impact your own tax preparation. This issue can easily be avoided by making sure The Health Plan receives an updated W-9 form, which provides us with the necessary information to correctly complete the 1099.

The Health Plan should always receive 1099s postmarked by January 31 for the prior fiscal year. The Health Plan files 1099 forms with the IRS on March 1, which gives us a month to correct information that we receive back, such as an incorrect address, payment amount, or tax name.

Furthermore, every September The Health Plan receives a report from the IRS that lists 1099s that were filed with a non-matching tax name and tax ID. These must be corrected in our system and verified with the IRS to show that we are managing the process, otherwise we could be subject to fees and penalties. Through the IRS, we can start assessing a 30 percent withhold on a vendor until we receive updated W-9 information. We want to avoid this to ensure a smooth process for everyone involved. Therefore, an updated W-9 is essential to our entire payment and reporting process.

For questions related to the status of your W-9 or 1099 at The Health Plan, contact Jeremy Piergallini, Senior Accountant, by calling The Health Plan or email him at [jpiergallini@healthplan.org](mailto:jpiergallini@healthplan.org).

# Rheumatoid Arthritis

## Coding and Patient Education



As you know, the prevalence of rheumatoid arthritis (RA) in the adult population is approximately one percent. However, your patients with RA require a significant investment in decision-making, patient education, and follow-up. According to the current American College of Rheumatology guidelines and clinical practice standards, patients with RA require



initiation of disease-modifying antirheumatic drug (DMARD) therapy within three months of diagnosis. Therefore, it is critical that your documentation, management, and reporting is accurate.

A review of our quality data shows considerable variation in the diagnosis and management of these patients.

- Correctly diagnosed with RA but not treated according to the accepted practice guidelines
- Incorrectly coded with RA when they have joint pain or other findings that require work-up. Too many primary care and specialty physicians are not following the American College of Rheumatology standards
- Some members appearing to have RA because claims have been submitted with an inaccurate ICD-10 diagnosis code

### What does this mean for you?

We need your attention to proper coding and your review and implementation of all of the clinical standards for the management of RA.

Practice tips for managing your patient population living with RA:

1. Create a list of all patients with RA in your practice
2. Review the list to ensure that these patients are receiving regular appointments and follow them closely to be sure that they are on a DMARD and possible glucocorticoid within three months of initial diagnosis
3. Script out (and time) the patient-education message that you and your staff will provide to new and established patients to be sure that you can deliver the information your patient population needs



Do you have the educational material that you need? Be prepared with a list of rheumatologists, physiatrists, and therapists to assist with these complex patients. Ensure beforehand that your specialty colleagues have appointments in the time frame that you need and that they will provide you with a timely report after the consultation.

## 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](http://healthplan.org). If you would like a copy please contact Provider Relations Customer Service at 1.800.624.6961, ext. 7901.

# New Preferred Provider Oncology Pharmacy

As of January 1, The Health Plan has selected Onco360 as its preferred oncology specialty pharmacy.

The Health Plan is always looking for ways to enhance the care our cancer patients receive, as well as the services we can offer to our oncology and hematology providers. Due to their clinical focus and distinctive approach towards pharmacy cancer care, Onco360 has demonstrated they have the capabilities to deliver both.



Onco360 is a full-service oncology specialty pharmacy that offers industry-leading service and administrative support.

- Comprehensive access to limited distribution oncology medications
- Access to oral, injected, and infused oncology medications
  - Infused medications delivered via home infusion services or shipped directly to a provider or provider's office for administration
  - Oral medications and injectables for self-administration shipped directly to the patient
- Board-certified oncology pharmacist-led clinical support and therapy management
- Prior authorization support
- Financial assistance services for patients

Oncology and hematology providers for The Health Plan are encouraged to begin referring new and existing prescriptions to Onco360. For more information about Onco360, including the medications they can provide and how to order, please visit [Onco360.com](http://Onco360.com), or call 1.877.662.6633.



## 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 for a period of no less than 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.

To view the training module for FWA, or for additional Compliance and FWA resources, go to CMS MLN at: [cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html](http://cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html).

## 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.



Reviewing Your Information for Accuracy Helps Patients Reach You

# Accurate Contact Information is Important

The Centers for Medicare and Medicaid (CMS) has completed its first round of auditing the accuracy of online directories on plans who market Medicare Advantage

plans. The type of inaccuracies cited among the plans included patients being unable to schedule an appointment at a listed practice location, incorrect phone numbers and suite numbers, and providers not accepting new patients.

THP is pro-actively auditing our online directories. Phone calls have been placed to a significant sample of practices throughout our service areas. In an ongoing effort to improve the accuracy of provider information listed within directories, CAQH ProView will ask providers to confirm that the phone number listed for each practice location is the primary method that patients should use when scheduling an appointment.

**How To Prepare:** On the Review Screen, the provider will be asked to confirm that the phone number entered in the Office Phone Number field should be used by patients to schedule an appointment.

**Impact:** <1 minute per location entry.

**Why:** Patients depend on the accuracy of provider directories when choosing a health plan and physicians. Inaccurate directories pose significant challenges for patients, contributing to delays in care, limiting choices of providers and masking problems with network adequacy.

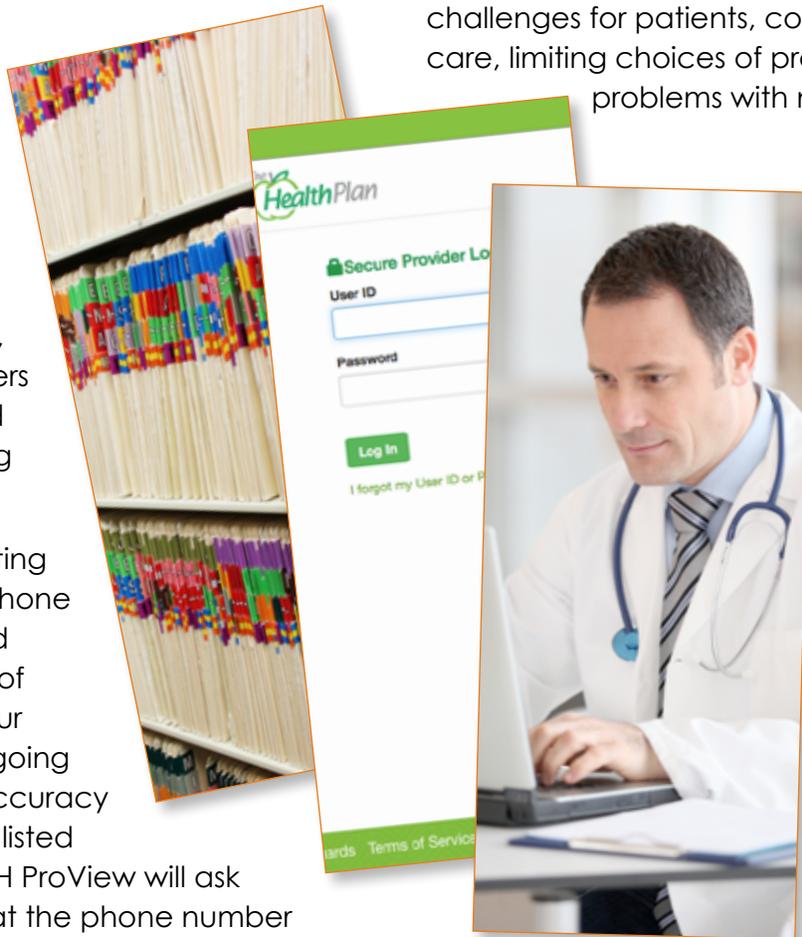
Improved provider directories will:

- Display an accurate account of the health plan network
- Identify providers who are accepting new patients and their contracted insurance coverage
- List providers who meet the language and location needs of patients

We thank you for your cooperation with this process. Accurate directories protect consumers from inadvertently visiting

out-of-network providers who could leave them with higher out-of-pocket expenses. To submit practice changes in writing, contact [hpecs@healthplan.org](mailto:hpecs@healthplan.org).

**Note:** These changes will NOT affect a provider's status in CAQH ProView or the ability for authorized participating organizations to view an already current and complete data profile.



# Accessibility and Availability of Care

## Appointment Availability Standards

We are committed to ensuring that the provider network is sufficient for members to receive care in a timely manner. Annually, quality management staff monitor access and availability through phone and on-site surveys.

### **Standards for primary care appointment accessibility include:**

- Regular/routine/preventive appointments: (ex: well exams, preventive care) should be seen within 30 days of a request to be seen.
- Routine follow-up/not preventive appointments: (ex: a medical concern such as blood pressure checks, wound checks) should be seen within 21 days.
- Urgent care appointments: (ex: disabling symptom such as burns, strains, sprains) should be seen within 24 hours.
- Not urgent/not emergent appointment: (ex: symptomatic care such as flu, cold, sore throat) should be seen within 72 hours.
- Emergent appointment: (ex: dramatic increase in mortality/morbidity such as chest pain, heart attack) should be seen immediately. If unable to see patient immediately, they may be directed to emergency services/ER.

### **Standards for behavioral health appointment accessibility include:**

- Routine appointment: (ex: patient condition considered stable) should be within 10 business days.
- Urgent appointment: (ex: worsening symptoms or new symptoms that if not treated could result in a more intense level of treatment) should be within 48 hours.



- Non-life threatening emergency appointment: (ex: extreme emotional disturbance or behavioral distress, considering harm to themselves or others, out of touch with reality, compromised ability to function) require prompt attention, should be seen within six hours.

### **Standards for obstetrician perinatal care appointment accessibility**

- Initial visit appointment: should be 8-10 weeks of pregnancy or earlier if high risk for ectopic pregnancy.

### **Waiting times within a primary care site should meet the following standards:**

Appointment waiting times should not exceed one hour for scheduled appointments.

### **24-hour telephone coverage**

The provider is responsible for arranging on-call and after-hours coverage to ensure 24-hour telephone access to all members.

All participating providers are required to maintain 24-hour, 7 day a week telephone access for their patients. The standard for returning a member call is 30 minutes.

For additional appointment accessibility and availability of care guideline information, please visit The Health Plan website at [healthplan.org/providers/products & services/quality-measures](http://healthplan.org/providers/products&services/quality-measures).

Please be sure that your staff is also familiar with the appointment accessibility & availability standards.

# Increasing Adolescent Well Visits Webinar

Thursday, June 8 from 12:15 – 2:15pm or Thursday June 15 from 8:15 – 10:15am

A free webinar, hosted by the American Academy of Pediatrics, will assist providers who want to increase the quantity and quality of adolescent well visits in their practice.

To better accommodate your busy schedule, choose from two dates to attend: **Thursday, June 8 from 12:15 - 2:15pm** and **Thursday June 15 from 8:15 - 10:15am**. Presentations will be led by Michele Dritz, MD, FAAP from Cornerstone Pediatrics and James Fitzgibbon, MD, FAAP from Akron Children's Hospital.

All attendees will receive an adolescent care office resource package, which includes a variety of tools you can use in your practice.

Register today at [www.OhioAAP.org/ACW](http://www.OhioAAP.org/ACW).

## Attendees will learn valuable information, including:

- Specific strategies around increasing adolescent well visits, both scheduling and attendance
- Utilization of Bright Futures recommendations as context for the well visit
- Improve adolescent attendance at comprehensive well visits through outreach via social media, electronic communications, tools and incentives for office staff, and using episodic care, acute care, and sports clearance to increase comprehensive well visits
- Differentiating between fear and lack of knowledge of adolescent health topics
- Best practices for adolescent immunization and use of reminder/recall tools in practice

## Ensuring HIPAA Compliance

# Patient Discharge Status Codes

A patient discharge status code is a two-digit code that identifies where the patient is at the conclusion of a health care facility encounter or at the end time of a billing cycle. It belongs in Form Locator 17 on a UB-04 claim form or its electronic equivalent in the HIPAA compliant 837 format.



The Health Plan evaluates the patient discharge status code against the facility provided census. The claim code is required to match the census for processing. If the claim does not, the claim will be denied.

For these codes and additional information, please see [cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0801.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0801.pdf)

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## Behavioral Health

# BH Follow-Up Care

As you know, it is important for patients with behavioral health conditions to receive timely follow-up care after discharge from an inpatient stay.

The Health Plan is asking for your cooperation and assistance to achieve the goal of a follow-up visit for these patients within 7 days of discharge. You can help facilitate this goal this by:

- Communicating to the hospital discharge planners that follow-up appointments should be scheduled within 7 days of discharge.
- Communicating to the scheduling staff in your office that it is imperative to schedule appointments for discharging patients within 7 days of discharge.

## Phone and Fax Updates

### Updated Utilization Review Phone Number

To ensure appropriate payment of claims, please call or fax all admission demographics for observation, inpatient, skilled and rehab, even if there is an approved referral on file, to The Health Plan's Utilization Review Department at their new telephone number 1.877.794.7152 or fax 1.888.329.8471.

### Faxing Clinical Information for Referral Review

When obtaining a referral and requesting clinical information from The Health Plan, please include the referral number, member's name and ID number on the cover page of the fax. This helps us to locate and review your referral request in a timely manner. All clinical information regarding referrals should be faxed to 1.888.329.8471.

### New Fax Number for Inpatient, Skilled and Rehab Reviews

To more efficiently review hospital admissions, a new fax line has been designated for all hospital reviews. Effective immediately please fax all reviews to 330.830.4397. Please include the patient's name, ID number and census number (if known) on all faxes.

## Review of Your Practice Information

The Health Plan strives to provide the most updated information to our members regarding our network provider information such as physical location, telephone number, hospital affiliation, is the provider accepting new patients, and any other restrictions you may have. Confirmation of what lines of business your practice participates in is also vital. Follow these steps to verify your information:

1. Log on to <http://findadoc.healthplan.org/>.
2. Search by LAST NAME and ZIP CODE or STATE. Our system will show all practitioners with the same last name. Select the provider to view all of the current information available on 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 request a report of all providers linked by tax number.
3. Any changes should be reported in writing. Please fax changes to 740.699.6169 or email [hpecs@healthplan.org](mailto: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.

## REMINDER: Prior Authorizations

Before transferring patients from facility to facility, prior authorization is required.

# Operations Phone Numbers

## The Health Plan Contact Quick Reference Guide

Benefits, Claim Status, Pre-Authorization, Eligibility (Provider and Member)		
Self-Funded (ASO)	Zappos.com	1.877.794.7153
	Murray Groups	1.877.794.7151
	All Other ASO Groups	1.888.816.3096
Benefits Only (Provider and Member)		
HMO, PPO & POS		1.888.847.7902
Medicare		1.877.847.7907
Medicaid		1.888.613.8385
Eligibility, Claim Status and Pre-Authorization (excluding ASO) (Providers Only)		
Provider Service Representatives		1.877.847.7901
Authorizations/Referrals		1.800.526.7511
Pharmacy		1.800.624.6961, ext 7914
Coordination of Benefits (COB) Issues and Questions (Providers or Members)		
All Lines of Business		1.800.624.6961, ext. 7903

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