ProviderFocus
A Publication of The Health Plan • December 2019

REMINDER: Signatures, Credentials & Dates Are Important

Each entry in the patient's medical record requires an acceptable signature and credentials, as defined by CMS, and the date on which the service was performed.

Inside this issue …

Assist Members in Lowering Lab Costs

Preferred Lab Network

The Health Plan (THP) has developed a preferred laboratory network that launches January 1, 2020. These labs were selected based on outstanding quality, access and service.

Preferred lab network providers are available to all Commercial members of The Health Plan and THP Insurance Company (including WV PEIA members that have selected THP as their health plan carrier). The preferred labs will be listed in the provider directory.

When possible and clinically appropriate, providers are encouraged to order tests from a preferred lab. By using a preferred lab, members will maximize their healthcare benefits and save on out-of-pocket costs. THP will waive applicable deductibles and/or coinsurances associated with a member's benefit plan when a member accesses services from THP's preferred lab network. A patient's responsibility for routine testing can be as low as $0.

LabCorp was selected to be part of THP's preferred lab network. LabCorp offers a comprehensive test menu of nearly 5,000 specialty and genetic tests. Contact LabCorp directly at labcorp.com/contact-rep if you don't already have an account or pickup schedule established with them.

Commercial members continue to have access to contracted labs that are part of The Health Plan network even if they are not part of the preferred lab network. The Health Plan will not limit those routine labs that are performed within a participating doctor's office.

Feel free to contact THP's Provider Relations Department at 1.877.847.7901 with questions.

Prior Authorization Notification

Changes as Per West Virginia House Bill 2351

During the 2019 regular session of the West Virginia Legislature, House Bill 2351 was passed. This bill affected several areas surrounding requirements and processes for prior authorizations (PA). The Health Plan (THP) is already performing many of the necessary pre-authorization mandates as part of best practice in support of ongoing member and provider services. This communication is designed to give you notification and direction regarding certain items the legislation addressed including:

- Prior authorization forms
- Process for incomplete prior authorization submissions
- Episode of care prior authorization requests
- Gold Star program (prior authorization exemption protocols)
- General information required to be placed on THP's website

Prior Authorization Forms: We have developed easy to use PA forms in both written and electronic formats. You can use the forms on our website and fax them into our utilization management (UM) department. Instructions for how to submit clinicals are included on each form.

Deadlines for PA requests: The Health Plan strives to make decisions as expeditiously as possible in order to meet our members' needs. We make decisions on urgent cases within two (2) business days and on routine, elective cases within seven (7) calendar days.

Incomplete PA submissions: Beginning January 1, 2020, The Health Plan will notify the requestor within two (2) business days of their electronic submission if additional supporting information is needed to complete the review. The requestor shall have three (3) business days to submit the requested information or the submission is considered denied.

Episode of care PA requests: The legislation allows for providers to submit episode of care prior authorization requests. Because of this, we allow you to define what is included in each episode of care. You tell us what treatments you want to include in an episode of care! Please visit our provider portal, myplan.healthplan.org, for the list of services requiring authorizations.

Gold Star program: Starting July 1, 2020 if a healthcare practitioner has performed a procedure at least 30 times per year and, over the previous six months, has attained a 100% approval rating, they may request to be a part of our Gold Star program. Send THP a request and evidence that the healthcare practitioner has met the requirements outlined above. Once THP verifies the provider's information, THP will update their system to allow the provider to obtain PA without submitting clinicals for review for that code(s). At the end of the six-month enrollment, the provider may request to be exempted again.

In order to ensure member quality and compliance with standards, THP reserves the right to audit charts during the provider's Gold Star period.

Information available on THP's website:

Codes requiring PA and other PA requirements are found on THP's provider portal: myplan.healthplan.org under "Prior Authorizations."

PA forms: Medical and downloadable forms may be accessed at myplan.healthplan.org under "Forms."

Questions may be directed to THP's Clinical Services Department at 1.800.624.6961, ext. 7643 or 7644.

Contracted Vision Providers

The Health Plan Medicare Advantage members (including SecureCare HMO, SecureChoice PPO and Dual-Eligible Special Needs Plan) will utilize Superior Vision for routine eye care (healthy eyes and materials) beginning January 1, 2020.

Providers must be contracted with Superior Vision in order to treat Medicare Advantage members of The Health Plan.

Contact Superior Vision at superiorvision.com or call 1.844.353.2900 Monday – Friday 8 AM – 9 PM EST to determine if you are a participating provider or to request to join their network.

Please continue to submit vision claims with a medical diagnosis to The Health Plan.

Feel free to contact THP's Medicare Customer Service number at 1.877.847.7907 if you have any questions.

eviCore Healthcare

Will Conduct Prior Authorizations

The Health Plan (THP) has partnered with eviCore healthcare to manage medical necessity review and prior authorization for Commercial, THP Medicaid and Medicare populations for the following services effective December 16, 2019:

- Radiology/Cardiology, including:
- Advanced imaging (including cardiac advanced imaging)
  - CT
  - MRI
  - PET
- Nuclear medicine (non-cardiac)
- Durable Medical Equipment and Sleep Studies

Effective January 1, 2020 eviCore will conduct medical necessity review and prior authorization for the Medicare population only for the following service:

- Post-Acute Care, including:
  - Skilled nursing
  - Home health
  - Long term acute care
  - Inpatient rehab

CPT codes requiring prior authorization are available on eviCore's website: evicore.com

REMINDER: CMS Annual Training Requirements

Compliance and Fraud, Waste and Abuse (FWA) training should be completed on an annual basis. Training may be completed through your own internal compliance program or by using training documents provided by The Health Plan which are available at myplan.healthplan.org. Training should be completed within 90 days of the initial hire date or the effective date of contracting and at least annually thereafter. Providers are required to maintain evidence of training for 10 years. This may be in the form of attestations, training logs or other means.

Provider Practitioner Manual

The Provider Practitioner Manual is updated bi-annually in July and December and may be accessed on The Health Plan's public website at healthplan.org/providers.

Hours of Operation Reminder to Providers

The Health Plan ensures that practitioners offer hours of operation that are no less (in number or scope) than the hours of operation offered to non-Medicaid or non-Medicare members.

Preventing, Detecting and Correcting Fraud Waste and Abuse

Special Investigations Unit

The Health Plan values its relationship with providers and recognizes the importance of providing valuable care to the community. The Health Plan is committed to ensuring quality care for its members and proper payment to providers for services rendered. Safeguarding payment integrity is an integral part of maintaining this mutually beneficial relationship, honoring the commitment to The Health Plan's network and its members, as well as complying with state and federal regulations.

Medicaid and Medicare guidelines require The Health Plan to have an effective program in place to prevent, detect, and correct fraud, waste and abuse. The Special Investigations Unit (SIU) meets that requirement and plays a vital role in ensuring payment integrity and in recovering overpayments as required by state and federal regulations.

SIU activities may include, but are not limited to, data mining, pre- and post-payment reviews, site visits, provider education, audits, and the facilitation of provider self-audits. In the event fraud is suspected, information is referred to the appropriate regulatory authorities and/or law enforcement. The SIU utilizes a skilled team capable of analyzing, auditing, and investigating claims.

Providers may be contacted by the SIU as a result of routine post-payment monitoring, or in response to a specific concern. Providers must comply promptly with requests for records or other information to ensure timely completion of audits and reviews.

Failure to provide timely responses to the SIU may result in an adverse impact on payment of future claims.

To report fraud, waste, or abuse, call THP's hotline at 1.877.296.7283 or email SIU@healthplan.org.

Changes to Behavioral Health Prior Auths

Guideline Changes as of November 1, 2019

To better serve THP's members and behavioral health providers, THP is implementing changes to behavioral health services requiring prior authorization effective November 1, 2019.

This change affects fully-insured, Medicaid and Medicare lines of business.

Employer funded lines of business will default to the group plan document.

Please note that THP also requires that prior authorization guidelines are followed to receive reimbursement when THP is the secondary payer.

Visit THP's provider portal to view a list of all behavioral health-related services that require prior authorization at myplan.healthplan.org/Provider/PreAuthLists

2019 Practitioner Experience Survey

Help Us to Help You!

Evaluation of overall practitioner experience with The Health Plan provides objective data necessary for problem identification and implementation of action plans necessary to improve interactions and remove any potential barriers to care. The survey is conducted annually every spring.

In 2019, there were 700 Practitioner Experience Surveys mailed to primary care physicians (PCP), behavioral health practitioners and secondary care physicians (SCP). We received 91 responses for a return rate of 13 percent. The return rate remains low but is up from past survey years. For 2020, The Health Plan is considering face to face Practitioner Surveys utilizing Provider Engagement Representatives during on-site visits to increase response rate and allow for immediate feedback in addition to the mailed version.

As with previous surveys, an internal benchmark of 90 percent positive response rate for all questions is The Health Plan's goal. Responses for 2019 remained positive and on track exceeding the goal in all categories with satisfaction scores for Utilization Management showing a 97.62% positive response for Preauthorization Criteria Flexibility, 97.62% for criteria fairly applied on a case by case basis, 98.73% for UM nurse navigator clinical expertise and 98.65% for Medical Director availability for peer to peer. Satisfaction scores for responses related to Case Management also exceeded the benchmark with: Nurse Navigators helped me find services/supported member access at a 94.03% positive response rate, Nurse Navigators encouraged compliance with my treatment plans at 97.01%, Nurse Navigators provide useful information to my patients/families at 98.53% and my patients who engage with nurse navigators have better outcomes at 96.97%.

Ongoing provider education to support identified provider topics of interest is planned through seminars, newsletters, email blasts, Provider Engagement Representative visits and The Health Plan's website. Our goal is to increase understanding regarding the various Clinical Service Programs, and how to contact our Medical Directors for discussion of review decisions. Providers may call the Clinical Services Department for peer to peer review discussion, support with THP Member Programs or with medical and behavioral service questions at 1.740.695.3585 or 1.800.624.6961, ext. 7644 or 7643. The provider engagement territory map is located on THP's website healthplan.org under "For Providers," "Overview."

The Health Plan appreciates your continuing participation and thanks you for your feedback.

Change to Pre-Authorizations

Physical Therapy, Occupational Therapy and Chiropractic Providers

Effective December 1, 2019, THP will no longer require pre-authorization for the first 20 visits for chiropractic services and the first 20 combined visits for physical therapy (PT) and occupational therapy (OT) per event and/or year.

Visit limitations for THP Medicaid and Medicare lines of business will follow a calendar year. Commercial plans (including HMO, POS, PPO and WV PEIA) visit limitations will be based on a contract year. Self-funded plans are excluded and default to the group plan document.

Palladian Health will review services for medical necessity and determine authorization status beginning with the 21st chiropractic and 21st combined PT/OT visits.

Please contact THP's Customer Service Department at 1.800.624.6961 if you have any questions.

CAHPS & HOS Scores and Helpful Hints

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) and the Health Outcomes Survey (HOS) are administered annually in the early spring. Physicians, such as yourself, drive performance on the following important CAHPS and HOS quality measures. The following two tables identify current survey results. A new survey will be administered in Spring 2020. For additional information visit cahps.ahrq.gov and cms.gov.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)				
Measure	HMO Rate	PPO Rate	Medicaid Rate	Commercial Rate
Annual Flu Vaccine	75%	74%	37%	50%
Getting Needed Care	88%	85%	84%	89%
Getting Appointments and Care Quickly	81%	79%	84%	87%
Customer Service	94%	93%	87%	93%
Rating of Health Care Quality	89%	86%	73%	76%
Care Coordination	88%	85%	86%	85%

Here are some CAHPS topics and discussion ideas for opportunities of improvement in the measures.

Care Coordination:

- When members have any lab tests, x-rays or any other tests explain to the member, "I will review the results with you."
- To provide the best care possible state, "I am going to review your medical record for new information and specialists you may have visited. It's important to me to manage and coordinate your care."

Getting Appointments and Care Quickly:

- Ask the member, "Would you like to schedule your next routine care visit before you leave the office today?"
- Tell the member, "We understand the need to get urgent care right away. When this occurs, please call our office for assistance."

Getting Needed Care:

- Say, "I want to make sure that you are getting the care, tests or treatments you need. Have those things been easy for you?"
- Tell the member, "If you have issues getting appointments with a specialist, please let our office know so we can assist you in getting a timely appointment."

Health Outcomes Survey (HOS)		
Measure	HMO Rate	PPO Rate
Improving or Maintaining Physical Health	67%	66%
Improving or Maintaining Mental Health	79%	79%
Monitoring Physical Activity	38%	46%
Reducing the Risk of Falling	54%	51%
Improving Bladder Control	47%	43%

Here are some HOS topics and discussion ideas for opportunities of improvement in the measures.

Falls Prevention:

- Tell the member, "I would like to talk about preventing falls with you. Falling is not a normal sign of aging, so we want to talk about preventing that from happening to you. Have you had any changes in walking, balance or had a fall since your last visit?" If yes, say "Let's talk about how to address that."

Improving or Maintaining Mental Health:

- Say, "Just as we talk about your physical health, it's equally important that we talk about your emotions and mental health. Do your emotions or mental health limit you in your work or daily activities? In the past month have you felt calm and peaceful?"

Improving or Maintaining Physical Health:

- State, "It's important that we talk about your physical health and if it affects your ability to get around in any way. Does your health right now limit you in climbing stairs or house cleaning? Has it been a problem in these areas over the past month?"

Urinary incontinence:

- Gently tell the member, "I have some questions about bladder control. This is an important health topic to talk about with each other, and I do not want you to be embarrassed. Have you ever talked with a healthcare provider about having an issue with urine leakage?" If yes, say, "Let's talk about how we can control and manage that."

Timely Claims Filing Deadline

Announcing Change for THP

Effective 1/1/2020, the timely claims filing deadline for professional and facility claims submitted to The Health Plan (THP) will be 180 days from date of service (DOS). This includes medical, behavioral health, vision, dental and pharmacy claims.

This change affects Fully Funded, Medicaid and Medicare lines of business.

Self-Funded lines of business will default to the individual group plan document.

Claims with DOS up to, and including, December 31, 2019 will follow THP's previous timely claims filing deadline of 365 days from DOS.

When THP is the secondary payer, THP claims must be submitted within 180 days from the DOS, but no later than 90 days from the date of the primary carrier's Explanation of Benefits (EOB).

If a claim requires a correction, you will have the greater of 180 days from the claim payment/ denial date or 180 days from the DOS to do so.

Low Income

Medicare Beneficiaries

The QMB (Qualified Medicare Beneficiary) Program is a Medicaid benefit that pays Medicare premiums and cost sharing for certain low-income Medicare beneficiaries. Federal law prohibits Medicare providers from collecting Medicare Part A and Part B coinsurance, copayments and deductibles from those enrolled in the QMB Program, including those enrolled in Medicare Advantage and other Part C Plans. If you are a PCP, THP has coded your patient rosters with a symbol to help you identify which of your patients meet this income level. Patient rosters are available on our secure provider portal located at myplan.healthplan.org.

Refer to CMS MedLearn Matters article for further guidance: https://cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersARticles/downloads/SE1128.pdf

The patient should make the provider aware of their QMB status by showing both their Medicare and Medicaid or QMB card each time they receive care. Patients should not receive a bill for medical care that Medicare covers. Patients cannot be charged for Medicare deductibles, coinsurance and copayments.

1.800.MEDICARE (1.800.633.4227).

Keep Provider/ Practice Information Up-To-Date

It is very important to remember to contact The Health Plan with any changes to your office location, telephone number, back up physicians and hospital affiliations. All of this information is gathered in order to provide the most current information to members of The Health Plan in the form of directories, whether they are electronic or paper.

The Health Plan has instituted a feature on our website to assist providers in verifying and updating information. It is located on the Find a Doc tool on THP's public website at healthplan.org. Search by provider's name and view the provider details on file. Click the "Verify/Update Practice Info" button to submit corrected information or verify that the listed information is current and correct.

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 and Section 5. This manual is available on our website, healthplan.org. If you would like a copy please contact Provider Relations Customer Service at 1.800.624.6961, ext. 7901.

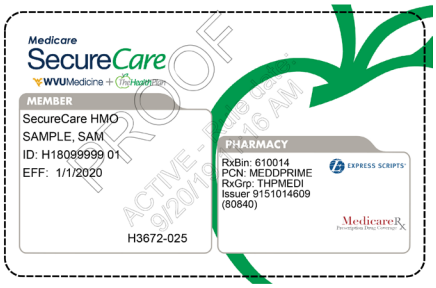
Facility Transfers Require Pre-Authorization

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

New Medicare Advantage Plan

The Health Plan Offering a New Plan

The Health Plan (THP) is pleased to be offering a new Medicare Advantage plan beginning January 1, 2020. The name of the plan is WVU Medicine – The Health Plan SecureCare (HMO). This plan is available to individuals residing in the West Virginia counties of Berkeley, Harrison, Marion, Marshall, Mineral, Monongalia, Upshur, Wetzel and Wood. Additionally, members of this plan will use a new membership identification card that looks like the image displayed on the right.



All in-network pharmacies/physicians/providers will continue to be available to members. However, by enrolling in this plan, members will enjoy lower out-of-pocket costs (e.g., copays and coinsurance) when utilizing WVU Medicine-affiliated providers and facilities. WVU Medicine-affiliated providers will also partner with THP to provide enhanced care coordination services to individuals enrolled in the plan.

To pre-authorize services, or for benefit and claims questions, please contact THP's Medicare Customer Service Department at 1.877.847.7907

Available Online

Clinical Practice Guidelines

The Health Plan and participating practitioners routinely review and update the preventive health guidelines and clinical practice guidelines. These are available to providers as a reference tool to encourage and assist in planning patients' care. To make the information more accessible and convenient for providers, THP has posted the complete set of guidelines online.

Visit healthplan.org/providers/patient-care-programs/quality-measures to view standards, guidelines and program descriptions for Quality Improvement, Disease Management and Behavioral Health practice guidelines.

Coding Guidelines

HEDIS® measures 2020

The Health Plan (THP) has developed a coding guide to assist you in correct billing to assist THP with capturing HEDIS® measures for 2020. The measures are divided into the following categories: Prevention and Screening, Respiratory Conditions, Cardiovascular, Diabetes, Musculoskeletal, Behavioral Health, Medication Management, Access/Availability of Care, Use of Services, Adjusted Utilization and other measures. Log in to the secure provider site, myplan.healthplan.org to find the applicable measures and CPT billing codes by clicking "Resource Library," "Quality Measures."

Required by CMS

Annual DSNP Training

If you provide services to members of The Health Plan's dual-eligible special needs plan (D-SNP), you are required to complete annual training by the Centers for Medicare and Medicaid Services (CMS). You may view the DSNP training slide deck and attest to the training by logging into The Health Plan's secure provider website, myplan.healthplan.org, "Resource Library", "Training and Education"