



# Provider Focus

A Publication of The Health Plan • August 2017

## 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 1.877.847.7901.

### Inside this issue ...

Provider Enrollment	
Notification .....	2
RBRVS Fee Schedule Changes...	2
National Drug Code (NDC) .....	3
CMS Annual Training	
Requirements .....	3
Depression Guidelines &	
Continuity of Care.....	4
Adult Dental Benefits .....	4
ID Cards.....	5
Low-Income Beneficiary	
Program.....	5
Medication Reconciliation	
Post-Discharge .....	6
Pharmacy Benefits .....	6
Dilated Eye Exams .....	7
Non-Physician Practitioner .....	7
Signatures, Credentials and	
Dates Are Important .....	7
Prior Authorizations .....	7
Therapy Code Modifier Billing....	8
Affirmative Statement	
Regarding Incentives .....	8



## Medical Management Review Criteria

Nationally-recognized clinical criteria is used when reviewing the medical appropriateness for the needs of the individual member, their circumstances, medical history and availability of care and services within The Health 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, ECT, and psychological testing.

You may call The Health Plan Clinical Services 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 case. InterQual® review worksheets are available upon request.

Please indicate if your request is emergent so that we may expedite the review. Scheduling the testing/procedure does not warrant an expedited review. Unless it is an emergency, scheduling should be done after being approved by The Health Plan.

# Provider Enrollment Notification

## MCO-WV Medicaid

Effective January 1, 2018, all providers who would like to deliver services to The Health Plan's Mountain Health Trust and West Virginia Health Bridge members are federally required to enroll and revalidate with West Virginia Medicaid. Once you receive the enrollment notification letter from The Health Plan, you have 120 days to submit your enrollment application and supporting documentation directly to Molina via the Molina Internet-Based Provider Enrollment Application Portal.

It is important to note that you will no longer be eligible to provide services to Medicaid members if enrollment is not completed according to the federal guidelines. This enrollment does not authorize or require the provider to render services to non-MCO/fee-for-service Medicaid members.

The following information will be needed to complete your enrollment:

- The name, phone numbers (primary, secondary, and fax), and email address of the person who will complete the enrollment application. You must have an email address to access the web portal.
- W-9 tax entity type (e.g. individual/sole proprietor, corporation, partnership, LLC disregarded entity, or LLC corporation).

For more information on this application, provider types, specialties and computer system requirements, visit Molina's provider enrollment web page by visiting [wvmmis.com/default.aspx](http://wvmmis.com/default.aspx) and clicking on the "Provider Enrollment" link.

If you have any questions about your upcoming enrollment,

please contact Molina provider enrollment at 1.888.483.0793 (option 4) or 304.348.3360, Monday-Friday from 8:00 am to 5:00 pm (EST). Once you are enrolled with Molina, they will notify The Health Plan.

We appreciate your service to our members, and look forward to working with you.



# RBRVS Fee Schedule Changes

## Medicaid

Changes have been made to update THP Medicaid fee schedules consistent with retroactive adjustments made by BMS to the state RBRVS fee schedule for January 1, 2017. Accordingly, the following impacts will be noted to claims:

- Unpaid claims for services from 1/1/2017 to present will be paid in accordance with current Medicaid Fee Schedule.
- Paid claims adjudicated prior to 5/1/2017 will be adjusted to correct payment levels. Adjustments will begin the month of September.

# Medicaid Requirements on Reimbursable Drugs National Drug Code (NDC)

Effective September 1, 2017, The Health Plan cannot reimburse for drugs, drug products, and related services, which are defined as a non-covered benefit by the Department of Health and Human Resource's Outpatient Drug Pharmacy Program.

In accordance with 42 U.S.C. § 1396r-8, THP must exclude coverage for any drug marketed by a drug company (or labeler) that does not participate in the federal drug rebate program. THP is not permitted to provide coverage for any drug product, brand name or generic, legend or non-legend, sold or distributed by a company that did not sign an agreement with the federal government to provide Medicaid rebates for that product.

Drugs administered by the physician and billed with a NDC must be rebateable to be eligible for payment, otherwise the drug will be denied. Providers can refer to the Centers for Medicare and Medicaid Services' website at [cms.gov](http://cms.gov) to determine if an NDC is manufactured by a company that participates in the Federal Drug Rebate Program or consult your wholesaler for assistance.

**Anyone**  
(i.e., employee, volunteer, provider, member, Board of Directors) can report abuse or compliance issues.  
Your report will be confidential and can be reported anonymously.  
To report suspected fraud, waste or abuse and/or suspected compliance issues call the hotline number shown here.

You may report anonymously.  
There can be **NO** retaliation against you for reporting suspected noncompliance in good faith.

## 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.

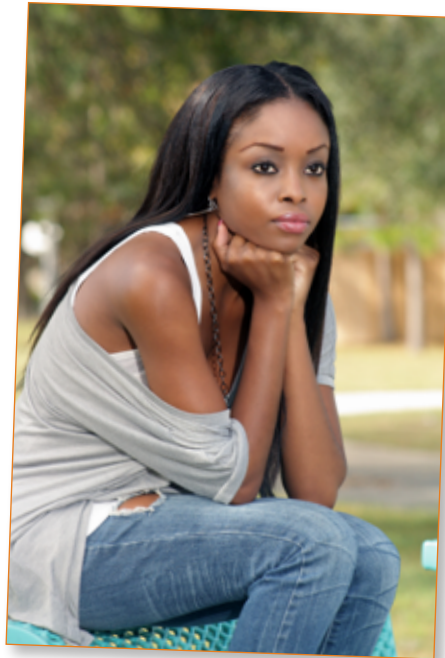
To view the training module for FWA, or for additional Compliance and FWA resources, go to CMS MLN at: [cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html](http://cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html).

Ensuring the Best Care

# Depression Guidelines & Continuity of Care

The Health Plan encourages primary care providers to evaluate patients for depression. THP has adopted the following guidelines and made them available on our website:

- Treatment of Patients with Major Depressive Disorder, published by the American Psychiatric Association can be accessed by visiting [psychiatryonline.org/guidelines](http://psychiatryonline.org/guidelines); and
- Adult Depression in Primary Care, published on the National Guideline Clearinghouse site and is the product of the Institute for Clinical Systems Improvement can be accessed by visiting [guideline.gov](http://guideline.gov).



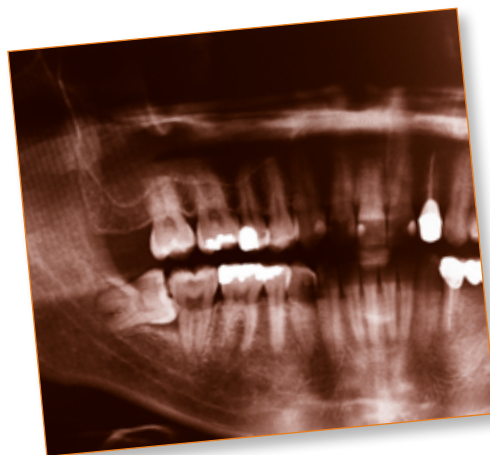
Continuity and coordination of care between behavioral and physical health care providers is an important aspect in the delivery of quality health care as behavioral and medical conditions can interact to affect an individual's overall health. The Health Plan's continuity of care consultation sheet is an excellent form to use in sharing information and can be accessed on our website. Release of information forms are also available if needed.

If you have questions regarding this change, or if you require assistance referring a member to a behavioral health provider, our Behavioral Health Services Department is here to help 24 hours a day by calling 1.877.221.9295.

Medicaid

## Adult Dental Benefits

A physician referral is not required for an initial evaluation by a dental provider. If extracting more than three teeth on the same date of service, the dental provider will be required to submit documentation related to the emergency extraction along with the claim.



Extraction of wisdom teeth are excluded unless they meet the emergent/urgent definition. Documentation is required to be submitted with the claim for all wisdom teeth extractions.

Please see provider manual for complete documentation relating to Medicaid Adult Dental and other important Medicaid guidelines.



# ID Cards

## THP is Removing Copays from All Member ID Cards

THP is removing copays from all member ID cards

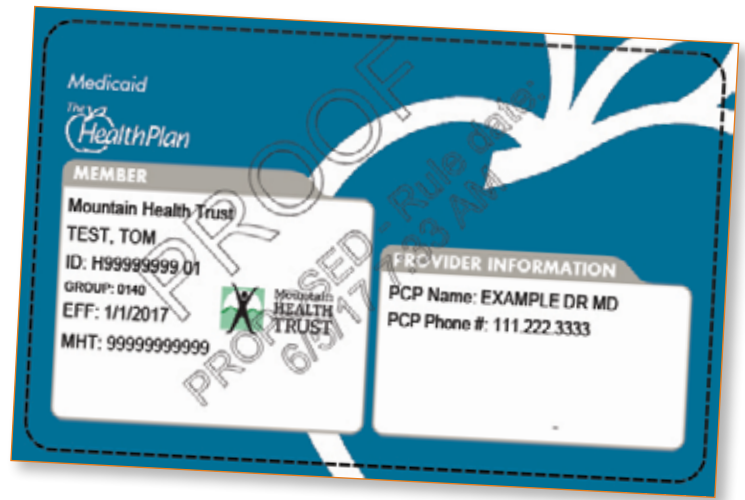
Providers will be required to utilize THP's secure provider web portal to look up copay information. The secure portal can be accessed at [providers.healthplan.org](http://providers.healthplan.org).

Please contact THP's Provider Relations Department at 1.877.847.7901 for assistance.

The process of changing over ID cards is extensive and will take time. You will see our old design and our new design (see graphic) for a short while. All redesigned cards will have the line of business located in the upper left-hand corner. Group numbers will be displayed on the redesigned ID cards.

Beginning July 1, 2017 Medicaid cards will be blue. This encompasses Mountain Health Trust, Medicaid Expansion (WV Health Bridge) & SSI populations.

Medicare cards will be gold. This includes the Medicare Advantage Plans (SecureCare and SecureChoice) and Medicare Supplement Plans. Redesigned Commercial, Self-Funded and PEIA cards are green.



# Low-Income Beneficiary Program

## Medicare

The qualified Medicare beneficiary (QMB) 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 co-insurance, copayments and deductibles from those enrolled in the QMB program, including those enrolled in Medicare Advantage and other Part C Plans. 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.

To learn more about the QMB program, refer to the CMS MedLearn Matters article for further guidance: <https://cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1128.pdf>, or call 1.800.MEDICARE (1.800.633.4227)

# Medication Reconciliation Post-Discharge

## HEDIS Coding Tips

Medication reconciliation is the process of reviewing and comparing discharge medications with the current medication list to ensure safety.

The medication reconciliation post-discharge (MRP) quality measure assesses members 18 years of age and older for whom medications were reconciled on the date of discharge through 30 days after discharge. The measure includes all acute and non-acute inpatient discharges, including but not limited to hospitals, skilled nursing facilities, and rehabilitation facilities.



Reconciliation documentation should be present in the outpatient record and should include evidence of the review and the date when it was performed. This quality measure is based on discharges, not on members, therefore a review should be completed within 30 days of each discharge. Listed below are the applicable codes to be billed for a medication reconciliation review.

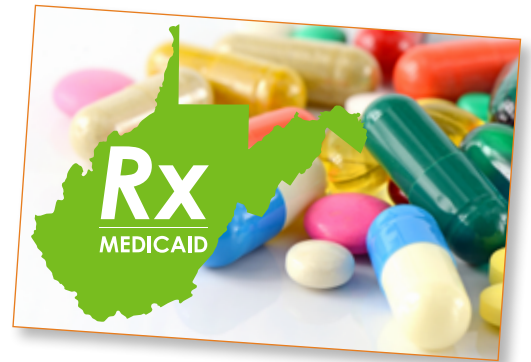
Medication Reconciliation CPT:  
99495, 99496, 1111F

## Changes to WV Medicaid

# Pharmacy Benefits

As of July 1, 2017 the WV Medicaid pharmacy benefit was taken back by the state. Pharmacy claims should be billed to Molina going forward. Notable exceptions not included on the PDL that are covered under the pharmacy benefit include:

- Depo-testosterone
- Hemophilia clotting factors
- Injectable progestin contraceptives (Depo-Provera, Medroxyprogesterone Acetate)
- Lupton Depot
- Makena
- Spinraza
- Synagis
- Vaccines (administered in a pharmacy only)



If you have questions about these changes, please contact our Pharmacy Services Department by calling 1.800.624.6961, ext. 7914

## Copay Waivers

# Dilated Eye Exams

Medicare Advantage members have a new benefit this year, allowing one free dilated retinal exam per calendar year with no copay regardless of a diabetes diagnosis or not.



Members with diabetes from our Commercial and Medicaid lines of business are entitled to one free dilated retinal exam per calendar year with no copay. THP coupon program encourages our members with diabetes to schedule their eye exam each year. The member does not need to present the coupon for copay to be waived. The claim for the diabetes eye exam and fundus report should be submitted to THP for payment of visit and the copay.

### Eye Exam Coding and Billing Table

CPT	(or)	HCPCS	(or)	**Category II
92002		S0620		2022F
92004		S0621		2024F
92012				2026F
92014				3072F
92134				
92225				
92226				
92227				
92228				
92230				
92235				
92240				
92250				
92260				

Ideally, our providers should bill a Category II CPT. If you have any questions, contact our Provider Relations Department by calling 1.877.847.7901.

## Non-Physician Practitioner

We are pleased to announce that effective July 1, 2017, Advanced Practiced Register Nurses (APRN) (certified nurse practitioner & certified nurse midwife) may be selected as a non-physician primary care practitioner. If you are a certified nurse practitioner and want members to have the option to select you as their non-physician primary care Practitioner please contact The Health Plan Provider Services Department at 1.877.847.7901.

## 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.



## REMINDER: Prior Authorizations

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



# Therapy Code Modifier Billing

## Coding Requirements



Therapy codes are not payable without one of the following modifiers to distinguish the discipline of the plan of care for the service that is being delivered.

You are required to use these modifiers for all plan types to ensure the correct billing category is applied.

- GO: Indicates services delivered under an outpatient occupational therapy plan of care
- GP: Indicates services delivered under an outpatient physical therapy plan of care

## The Health Plan

# Affirmative Statement Regarding Incentives

The Health Plan bases its decision-making for coverage of healthcare services on medical appropriateness utilizing nationally recognized criteria. Incentives are not offered to providers or employees of The Health Plan involved in the review process for issuing non-authorization, nor does The Health Plan specifically reward, hire,

promote, or terminate practitioners or other individuals for issuing denials of coverage. Also, no incentives are given that foster inappropriate under-utilization by the provider. The Health Plan does not condone under-utilization or inappropriate restrictions of healthcare services.

The Health Plan • 1110 Main Street • Wheeling, WV 26003 • 1.800.624.6961 • [healthplan.org](http://healthplan.org)



1110 Main Street  
Wheeling, WV 26003