



ProviderFocus

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Provider Practitioner Manual

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

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COVID-19 Guidelines

THP Following CMS and BMS Measures

The Health Plan is following the temporary measures related to healthcare services instituted by the Centers for Medicare and Medicaid Services (CMS) and the Bureau for Medical Services (BMS) during the coronavirus (COVID-19) pandemic.

Please refer to CMS' guidelines related to COVID-19 for THP members with Medicare and fully-funded (including POS, PPO, HMO, WV PEIA) coverage. Those guidelines may be accessed at <https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page>

BMS guidelines related to COVID-19 will be followed by THP for Medicaid members. Please visit the "News and Announcements" section of BMS' website at [https://dhr.wv.gov/bms/Pages/Coronavirus-Disease-2019-\(COVID-19\)-Alerts-and-Updates.aspx](https://dhr.wv.gov/bms/Pages/Coronavirus-Disease-2019-(COVID-19)-Alerts-and-Updates.aspx) to access the latest information related to COVID-19.

Self-Funded plans default to the group plan document.

The Health Plan is also following BMS and CMS guidelines for telehealth services rendered during the COVID-19 pandemic.

Bill the appropriate CPT/HCPCs code and use 02 for the Place of Service if billing on a HCFA 1500 form.

For Medicaid members only, if billing on a UB04 form, bill the appropriate CPT/HCPCs code with the -GT modifier.

These are temporary measures due to the COVID-19 crisis and The Health Plan reserves the right to re-evaluate at a later date.

Contact The Health Plan at 1.800.624.6961 if you have any questions or need further assistance. 🍏



Social Determinants of Health

Help Us Help Your Patients

Health equity is when everyone has the opportunity to be as healthy as possible. Health disparities are differences in health outcomes and their causes among groups of people. Social determinants of health (SDoH) are conditions that shape a patient's health risks and outcomes, including where people are born, live, learn, work, and play. CDC Healthy People 2020 highlights the importance of addressing SDoH by including "create social and physical environments that promote good health for all" as one of the four overarching goals for the decade. We need to understand health disparities our members are facing, and address disparities identified by race and ethnicity, socioeconomic status, geographic location, disability, and/or sexual orientation across a range of conditions.

In 2017 a national initiative began to capture, code, and refer to social and governmental programs, any members who self-identified an SDoH barrier. Much of the data gathered by providers related to SDoH lives in the electronic medical records as a result of health risk assessment documentation.

To help us understand the SDoH and barriers impacting each of your patients and assist in providing services to support their needs, here are a few points for you to consider:

- Incorporate questions related to SDoH into your patient assessments
- After a health risk assessment is completed, any SDoH barriers identified should be coded appropriately on the claim.
- When indicated, social needs resources can be given to the patient. A great resource is Aunt Bertha, a website that has information on a network of social care providers based on zip code. auntbertha.com
- Call The Health Plan and ask for a care navigator or a social worker who can help with these referrals.

The existing SDoH diagnosis code range, Z55-Z65, has been labeled as "Persons with potential health hazards related to socioeconomics and psychosocial circumstances." Please be vigilant in assessing code sets when determining any and all SDoH barriers to patients and code the claim accordingly.

If you have any questions or concerns, please contact your provider engagement representative. Contact information may be found at healthplan.org "For Providers," "Overview," "Meet the Provider Engagement Team."

For more information please visit these CDC websites:

https://www.cdc.gov/nchs/healthy_people/hp2020.htm

<https://www.cdc.gov/minorityhealth/strategies2016/index.html> 🍏



REMINDER: Signatures, Credentials and 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. 🍏

Updated Information

Access to Care Standards

THP's access to care standards for PCPs, specialists and for prenatal care have changed to align with the Bureau for Medical Services' (BMS) requirements. See updated timeframes outlined in the tables below.

Provider Accessibility Standards for PCPs Include:

PCPs available 24/7 with appropriate call coverage and after-hours answering service for urgent/emergent conditions.	
Routine other than preventive care (exemptions permitted when PCP capacity is temporarily limited)	Within 14 calendar days
Adult urgent care	Within 48 hours
Pediatric urgent care	Seen same day
Emergent cases	Seen immediately or refer to an emergency facility
Physical exams	Within 180 calendar days
Preventive/EPSTD	Within 30 days
In office wait time	Within one hour of appointment time

Provider Accessibility Standards for Specialists

New or established patients	Within 30 calendar days <i>Appointment access should be granted sooner for cases where it is medically appropriate or indicated</i>
In office wait time	Within one hour of appointment time

Provider Accessibility Standards for Prenatal Care

Initial prenatal visit	Within 14 days of when a woman is found to be pregnant
First and second trimester visits	Within 7 calendar days
Third trimester visit	Within 3 calendar days
High risk pregnancy	Within 3 calendar days of identification of high risk

Facility Transfers Require Pre-Authorization

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

Resubmitting Paper Claims – Professional

To avoid a claim denying as a duplicate claim, THP requires a new CMS 1500 claim form when resubmitting a professional claim on paper. Box 22 on the 1500 form must contain one of the following codes:

- 7 Replacement of prior claim
- 8 Void/cancel prior claim

Attach a copy of the payment voucher with the member circled or underlined.

Include a clear explanation and/or additional documentation as to why the claim is being re-submitted.

Indicate on the claim form "corrected" or "resubmitted claim". 🍏

Non-Par Denied Claims

Submitted claims must accurately reflect the rendering provider. If a claim for a Medicaid member is denied due to the rendering provider not being enrolled with BMS, it is inappropriate to resubmit the claim indicating a different provider rendered the service. These resubmitted claims will be denied, and a referral will be made to our Special Investigation Unit (SIU). 🍏

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. 🍏

Review Determinations



Contacting the Medical Director

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's 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. A determination may change with the addition of new information imparted during a conversation between the two physicians.

When physicians make such an inquiry, you should have the patient's name, referral number and/or ID number available for our medical director to quickly access the electronic record at the outset of the call. It is not mandatory to have this information 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 system.

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.

Medical Director Contact Numbers		
Referral Type	Contact Numbers and Email Forms	
Medical Determinations	800.624.6961 ext. 7644	740.695.7644
Pharmacy Services	800.624.6961 ext. 7885	740.695.7885
eviCore – Must be scheduled in advance	877.791.4104	via email www.evicore.com/provider/request-a-clinical-consultation
Palladian	855.748.6499	

Be on the Lookout Provider Surveys

Practitioner experience surveys are distributed annually to PCPs, behavioral health providers and secondary care providers. If you receive a survey, we encourage you to take the time to complete and return the survey.

Information obtained is used to:

- Create action plans to improve interactions and remove potential barriers to care
- Improve communication and increase understanding between THP and providers
- Plan webinars, newsletter articles, email blasts and other correspondence. 🍏

DSNP Annual Training

Required by CMS

The Centers for Medicare and Medicaid Services (CMS) require annual training of providers that provide services to members of THP's dual-eligible special needs population (D-SNP).

A change has been made to the training requirements and the method of providing training. THP's provider engagement reps will contact those providers providing services to five or more D-SNP members in a calendar year to complete and attest to the training.

Training materials are available on The Health Plan's secure provider website, myplan.healthplan.org under "Resource Library," "Training and Education." 🍏

Required by CMS

Cultural Competency Training



The West Virginia Bureau for Medical Services (BMS) requires that Medicaid enrollees receive services in a culturally competent manner.

The Centers for Medicare and Medicaid Services (CMS) states that Medicare Part C and Part D plans may not discriminate based on race, ethnicity, national origin, religion, gender, sex, age, mental or physical disability, health status, receipt of health care, claims experience, medical history, genetic information, evidence of insurability or geographic location.

Non-discrimination requirements include providing equal access to members with limited English proficiency or limited reading skills.

Cultural competency training is tracked by The Health Plan and providers completing cultural competency training are noted in The Health Plan's Provider Directory.

The Health Plan offers cultural competency training through the provider engagement representative assigned to your county or via a cultural competency training slide deck. The presentation is located at myplan.healthplan.org "Provider Resources," "Training and Education." Upon completion of training, please sign and return the attestation form to attest to completion of this training. 🍏

Provider/Practice Information

Important to Keep 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. 🍏

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. 🍏



THP Rx Clinical News and Notes

Pipeline Approvals in February

The Federal Drug Administration (FDA) has recently released three new drugs. At this time none of these drugs are covered by The Health Plan.

Trijardy XR FDA Approved

The FDA approved Trijardy™ XR extended-release tablets on January 27, 2020. The first three-drug combination for managing diabetes, Trijardy XR combines metformin with Jardiance® (empagliflozin), a sodium-glucose co-transporter 2 (SGLT2) inhibitor, and Tradjenta® (linagliptin), a dipeptidyl peptidase 4 (DPP4) inhibitor. Marketed jointly by Eli Lilly and Boehringer Ingelheim, all three branded drugs are indicated for the treatment of adults who have type 2 diabetes. Metformin reduces production of glucose, lessens its absorption and improves insulin sensitivity. SGLT2 drugs block reabsorption of glucose by the kidneys to increase glucose excretion in the urine. DPP-4 inhibitors decrease the activity of an enzyme that breaks down hormones that help to maintain blood glucose control. Including all three in one tablet is more convenient for patients who need more than one drug to control blood sugar. To be produced in four different strength combinations, Trijardy XR will be taken one time each day by patients who already are using diet, exercise and other diabetes drugs, but who still need more help to lower blood sugar levels. As with all drug products that include metformin, Trijardy XR carries a boxed warning and has a medication guide about the possibility that it may cause lactic acidosis. Trijardy will not be added to The Health Plan formulary until formulary development is completed.



Esperion

On Friday February 21, 2020 The FDA approved bempedoic acid (Esperion): an adenosine triphosphate (ATP) citrate lyase (ACL) inhibitor for once-daily treatment of patients who have elevated LDL cholesterol and who need additional LDL-C lowering despite the use of current therapies. This is an oral medication.

Tepezza

Also during February, the FDA approved Tepezza, the first drug to treat a rare autoimmune condition known as thyroid eye disease (TED) also known as Graves' orbitopathy. The FDA described this action as a "milestone for the treatment of thyroid eye disease" as this biologic offers patients a significant, improved course of the disease, likely sparing them from progressive disfigurement, pain, and vision loss with only the prospect of repeated surgeries for any relief. Prescription cost is \$14,900 per vial. 🍏

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_21. 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. 🍏

Reminder

CMS Annual Training

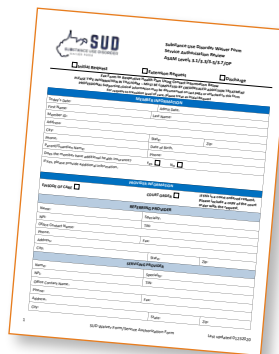
Compliance and FWA training should be completed on an annual basis. Training may be completed through your own internal compliance program or by using training documents provided by The Health Plan which are available at myplan.healthplan.org. Training should be completed within 90 days of the initial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



Fillable SUD Waiver Form

Newly Developed and Accepted

A universal Substance Use Disorder (SUD) Waiver Form has been developed and accepted by all of the West Virginia managed care organizations to request SUD services for Medicaid members. Completion of this form in its entirety may reduce the number of requests for additional clinical information to support SUD services for THP members.



The new SUD form is available in fillable format on THP's provider portal located at: myplan.healthplan.org "Forms," "Behavioral Health Forms," "Paper Forms."

Use of the new universal form is not mandatory. THP will continue to accept the THP specific version of the SUD service request form still in use for other lines of business if Medicaid providers fill it out in error or find it preferable.

For assistance or questions, please contact the Clinical Services Department at 1.800.624.6961, ext. 7644. 🍏

Emergency Room Reimbursement

The Health Plan (THP) is following the Bureau for Medical Services' (BMS) guidelines pertaining to reimbursement for emergency room services rendered to Medicaid members.

The enhanced reimbursement is all-inclusive and includes:

- Use of emergency room
- Routine supplies (such as sterile dressings)
- Minor supplies (bandages, slings, finger braces, etc.)
- Pharmacy charges
- Suture, catheter, and other trays
- IV fluids and supplies
- Routine EKG monitoring
- Oxygen administration and O2 saturation monitoring

Diagnostic procedures, including lab and radiology, may be billed separately and in addition to the emergency room services. 🍏

Billing Outpatient Services Performed in Hospitals

Effective January 1, 2020, CPT/ HCPCs codes are required to be submitted with the applicable revenue code for all outpatient services provided to Medicaid members in an acute or critical access hospital setting. Claims billed with revenue codes submitted without the corresponding procedure code(s) will be denied.

If training is conducted in a group setting, please submit a separate form for each provider attesting to the training. 🍏

Qualified Medicare Beneficiary 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 co-insurance, 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, co-insurance and copayments. 1.800.MEDICARE (1.800.633.4227). 🍏

CMS Requests Data Review

NPPES to Improve Accuracy of Provider Directories

The Health Plan strives to maintain an accurate provider directory to assist our members in locating a provider to treat their health care needs. The Centers for Medicare and Medicaid Services (CMS) has made it their goal to increase the accuracy of provider directories and is requesting that providers review their demographic information in the National Plan and Provider Enumeration System (NPPES) registry and make necessary corrections to the data and then attest to the accuracy of the data.

NPPES has recently added the ability to enter multiple provider addresses where providers see patients for appointments. The goal is to reduce the need for payers to contact providers to verify demographic directory data and improve the accuracy of provider directory data by treating the certified NPPES data as a valid source for provider directory data in audits of Medicare Advantage directory accuracy.

A new certification function has been implemented in NPPES that physicians can use to certify that the NPI data is accurate or edit the NPI application. The Health Plan and CMS request that providers review, update and certify that their information in NPPES is accurate. The date of certification is captured in the NPPES database. Follow this link to access the NPPES NPI registry: <https://npiregistry.cms.hhs.gov/> to verify and update provider demographic information. There is no cost to providers to edit and certify information accuracy. 🍏

