**Access to Nurses**

There is always access to a nurse to assist practitioners regarding information about the utilization management process and the authorization of care.

The nurse information line provides practitioners with access to a nurse 24 hours a day, 7 days a week and has been a feature of The Health Plan since 1994.

You may contact the nurse information line by calling a nurse directly at 304.639.8597 or by calling The Health Plan’s St. Clairsville office at 740.695.3585 or toll-free at 1.800.624.6961.

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**The Health Plan**

**Vibrant. Personal. Energetic.**

**Introducing Our New Look**

The Health Plan would like to introduce to you our newly rebranded image. It better reflects the trust and confidence our providers have come to count on from us here at The Health Plan.

Our new image is as vibrant, personal, and energetic as the service we strive to provide. The apple has long been a symbol for good health and remains a visual representation of our commitment to the health of our communities that we serve.

Our rebranding is more than a new identity. It reflects our mission: We are an established community health organization, that delivers a clinically-driven, technology-enhanced, customer-focused platform by developing and implementing products and services that manage and improve the health and well-being of our members. We achieve these results through a team of health care professionals and partners across the community.

We are committed to:

- To advancing the QUALITY of care delivered by our providers and received by our members using the best available practices.
- To providing superior SERVICE using the highest set of standards for personal respect, courtesy and compassion for our members, providers and other health care systems.
- To GROWING through innovation, creativity and hard work.
- To offering the highest level of INTEGRITY and RESPECT for our employees, members, providers and partners through a positive attitude of honesty, sincerity and determination.
- To each of our COMMUNITIES that our products and services support.
- To supplying a positive atmosphere for our EMPLOYEES, allowing them the opportunity for personal growth that meets the needs of our company, our clients and our members.

We at The Health Plan would like to take this opportunity to thank you for your past and present support of The Health Plan and look forward to our continued partnership. The network/provider relations staff would also like to wish you a Happy New Year and continued success throughout 2015.
Effective January 1, 2014 The Health Plan started offering a Medicare Advantage (SecureCare) D-SNP program in some regions of West Virginia and Ohio. Although there are various types of Special Needs Programs (SNP) which target special populations, The Health Plan program encompasses the dual eligibles who are individuals entitled to Medicare and are also eligible for some level of assistance from their state Medicaid program. Their services are coordinated so that the member obtains the maximum benefits of their dual coverage.

SNP Model of Care (MOC)
The SNP MOC is comprised of 11 elements outlining the plan for delivering comprehensive case management services to Medicare Advantage member with special needs.

In the 1st, 2nd and 3rd quarter ProviderFocus, elements 1-8 were summarized. The following will summarize elements 9 through 11.

9. Communication Network

- Employ a variety of structures and strategies to ensure constant and efficient communications between members, providers, Health Plan employees, caregivers, and regulatory agencies.
- Much of the communication process is coordinated through use of internal information system components.
- Avenues for communication with members, providers, other stakeholders include direct mail, newsletters, web-based communications, telephonic communications, and education health activities such as health fairs, seminars and web-based conferencing.
- Capabilities exist within the organization to handle special communication needs due to hearing, vision or reading impairments or language translation difficulties.
- Member care team meetings provide the greatest depth of contact between the various care components and the member. These are held through teleconference or person-to-person meetings.
- Written communications are prepared for special needs members by the Government Programs Department and include welcome kits, newsletters, benefit summaries, evidence of coverage documents, provider listings and other general informational items. These are available in written form as well as on the website.
- After hours and weekend urgent needs can be directed to The Health Plan nurse on call.
- Customer service and outreach areas handle the bulk of inquiries from members and providers. Dedicated phone banks are staffed daily from 8:00 am through 8:00 pm, EST.
- Electronic communications are done in a secure electronic environment and comply with HIPAA standards for data transmission.
- Communication effectiveness is monitored at corporate and departmental levels throughout the organization.

10. Care Management for the Most Vulnerable Subpopulations
The Health Plan promotes the management of care and services and facilitates access to care for our dual eligible members. Gaps in care are identified and resources are provided to enrollees to improve their health care status. We pro-actively identify and enroll members with complex/catastrophic diagnosis, multiple health care needs, and chronic conditions into specialized programs that provide early interventions, education and coordination of care and effective communication of an individualized care plan. The common thread for the dual eligible population is the lack of resources as qualifying is based on income.

Vulnerable subpopulations are defined as members:

- With multiple chronic conditions
- That are the frail, elderly age over 85
Opt-in/out of Medicare for Part D Prescription Coverage

On May 23, 2014, The Centers for Medicare and Medicaid Services (CMS) published a final rule addressing various changes to the Medicare Advantage (Part C) and Medicare Prescription Drug Benefit (Part D) programs. Effective December 1, 2015, the prescribing practitioner must be either enrolled or affirmatively opted-out from the Medicare program.

Part D plans and their prescription benefit managers will be required to deny claims for prescriptions written by eligible professionals who 1) do not have a NPI; or 2) do not have a valid Medicare enrollment or opt-out affidavit on file with a Medicare A/B administrative contractor (MAC). This could result in point of sale denials that impact patient care.

CMS stated that the purpose of the final rule is to ensure that Part D drugs are prescribed by qualified practitioners who are eligible to prescribe under state law and under the Medicare program requirements (e.g., not excluded from Medicare or Medicaid participation.)

It is critical that all prescribers writing prescriptions covered by Part D maintain a valid NPI and either enroll in Medicare or make sure they have a valid opt-out affidavit on file with their MAC.

Redesigned. Rebranded.
Member ID Card

As we begin the first quarter of 2015, part of our redesigned and rebranded image includes updated member ID cards. This is a plastic card. There is no expiration date on the card. We will only issue a new ID card if they have a change in benefit, eligibility (i.e., a dependent is no longer eligible), their employer group, or a replacement for a misplaced or lost card.

The deductible will also no longer be displayed on the card; therefore, you will need to contact our Customer Service Department at 740.695.7901 or 1.800.624.6961, ext. 7901 to verify the member’s deductible and/or eligibility.

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"These changes continue to directly reflect our mission as an established community health organization."

For your convenience, you can also contact our Customer Service Department at hpecs@healthplan.org for assistance.

These changes continue to directly reflect our mission as an established community health organization that delivers a clinically-driven, technology-enhanced, customer-focused platform by developing and implementing products and services that manage and improve the health and well-being of our members. We achieve these results through a team of health care professionals and partners across the community.

For your convenience, you can also access the member information, including eligibility, claims, and the deductible through our provider secure website. If you are not currently registered for our website, register now by completing a form at healthplan.org. You can also email our EDI Support Department at hpecs@healthplan.org for assistance.

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2014 CAHPS Medicare Survey Results

The 2014 CAHPS satisfaction surveys have been completed for our Medicare lines of business. The results for all measures, except two, were at or above the national average. “Overall Rating of Specialist” fell below the national average for both the SecureCare HMO line of business in our St. Clairsville region and the SecureChoice PPO in all regions.

The level of satisfaction for one measure, “Care Coordination,” declined in all regions.

The Health Plan will continue to focus on care coordination and will start to provide more information on health literacy in the coming months to facilitate better understanding between providers and their patients.

For a detailed summary of the CAHPS survey results, call the Quality Improvement Department at 740.695.7659.

The Health Plan has announced that five employees recently passed ‘Freedom From Smoking’ certification from the American Lung Association.

The ‘Freedom From Smoking’ program has been helping smokers quit for over two decades. The eight module program is offered as a group clinic in many areas of the country. Participants in ‘Freedom From Smoking’ develop a personalized step-by-step plan to quit smoking. Each session uses a positive behavior change approach and encourages participants to work through the problems and process of quitting individually as well as in a group. Evidence has shown that ‘Freedom From Smoking’ is very effective at helping smokers quit.

For more information on this program, please call The Health Plan at 740.695.3585 or 1.800.624.6961, ext. 7659. If your patients have any questions concerning their benefits for smoking cessation agents, or any questions in general about the agents they can call The Health Plan at 740.695.3586 or 1.800.624.6961, ext. 7914.

Evidence has shown that Freedom From Smoking program is very effective at helping smokers quit.

Please be aware that in the early part of 2015, The Health Plan will begin to request medical records as proof of diagnosis for certain chronic conditions, such as rheumatoid arthritis. There is a potential that this requirement will affect claims payment and we may need to pend claims until the record is received to confirm diagnosis. In the future, this project may expand to include other chronic conditions.

Freedom From Smoking Certification Awarded

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You know smoking is bad for your patients. They have probably thought about quitting or they may have even tried to quit. If they are still smoking, they may need help to quit. It is not easy, but it can be done, with the right support and tools. Many, many people have kicked the habit. It is never too late to stop smoking; by quitting your patients can live a longer, healthier life.

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continued from page 2

- Are blind or disabled
- Development of ESRD after enrollment
- Near the end-of-life

Identification of the vulnerable subpopulations is through diagnosis reports, 7 and 30-day readmission reports, high cost reports, HRA scoring, behavioral health diagnosis, dual diagnosis and referral from member, caregiver, physicians, social agencies, and other areas of medical management, such as hospital review.

Benefit of add-on services:
- Dual eligible members will receive many add-on services over and above original Medicare defined benefits.
- Included in the benefits are health risk assessment, care coordination, case management, disease management, preventive service reminders, customer service and outreach, medication therapy management, member care team, utilization management, educational materials, interpreter services. In addition to those FFS Medicare benefits, there will be a zero premium for benefits which include routine vision and eyewear, transportation, over-the-counter items, dental, and hearing.

11. Performance and Health Outcome Measurement
- The Health Plan utilizes claims data, pharmacy data, CASETRACKER, census information, HEDIS data, referral systems, health risk assessments and provider systems for data mining.
- Data is used for reporting and analysis and to develop interventions where necessary to improve the quality and efficacy of our programs.
- Data is analyzed by appropriate staff specific to the subject matter and compared against industry benchmarks and/or internal plan-specific goals.
- Reported to variety of committees including Medical Directors Oversight Committee, Continuous Quality Improvement Committee, Focus Group and the Quality Improvement Committee.
- The Health Plan HCC data coordinator/analyst collaborates with programmers to develop reports necessary for the monitoring of the performance of the D-SNP MOC, as well as analyze and report on the overall effectiveness of the program.

2014 Practitioner Satisfaction Survey

There were 4,162 practitioner experience surveys mailed to primary care physicians (PCP), behavioral health practitioners and secondary care physicians in 2014. We received 445 responses for a return rate of 11 percent which was a 1.75 percent increase over 2013. The survey is conducted to identify areas that we can improve in medical management. The results are analyzed and compared to the prior year.

Provider education is provided through seminars, newsletters and the website on various medical management programs, contacting medical directors for case discussion, preauthorization and new technology reviews.

In 2015 there will be two changes to the survey:

1) The name will change from “Practitioner Satisfaction Survey” to “Practitioner Experience Survey” as now described by NCQA.

2) Question “Hospital on-site reviewers presented me with options for care and services for my patients at time of discharge” will be deleted due to the last on-site nurse being discontinued as of 8/22/14.

“All responses were above the 90% benchmark for Agree or Strongly Agree.”

You may call the Medical Management Department for any issues or with questions at 740.695.3585 or 1.800.624.6961, ext. 7643 or 7644 or the behavioral health department at 740.695.7896 or 1.877.221.9295.
Billing a Sick Visit with a Well Exam

Remember the following guidelines.

Patients presenting for a routine preventive exam often mention symptoms of acute illness during their visit. It is acceptable to bill both a preventive “well-exam” on the same claim and a problem focused “sick visit” as long as you remember a few key guidelines.

- The problem must be significant enough to require additional work above what is routinely done during a preventive exam.
- A separate history of present illness and review of systems must support the problem focused visit.
- Time spent on the preventative portion of the visit cannot be counted towards the problem focused portion.
- Modifier 25 must be used for the problem focused CPT code.
- The diagnoses submitted should support both the well visit and the problem focused CPT codes.
- The medical record should clearly differentiate the “well” and “sick” portions of the service. Many offices find it easiest to make separate notes.
- Make sure patients are aware that a copay may be required for the problem-focused visit. This can be done by posting signs in the waiting or exam rooms or by notifying them when they schedule their annual exam.

CMS Requires Annual Provider Training for Fraud, Waste, and Abuse Compliance

The Health Plan has developed provider training modules for necessary documented training of fraud, waste, and abuse (FWA) and compliance.

CMS requires documentation from our providers of the completion of the compliance training in FWA and Special Needs Plan (SNP) 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. We have provided attestation statements for completion on our website or print the form, sign, and send or fax it to Provider Relations at 740.699.6169.

If you are a contracted delegated credentialing entity, contracted physician hospital organization (PHO) or individual practice association (IPA), you are considered First Tier, Downstream or Related Entity (FDR) and provide services to our Medicare Advantage programs; in addition to FWA and general compliance training, you are required to show proof of how you disseminate your Code of Conduct or Standard of Conduct to your employees and your downstream entities.

The completed attestation forms will be returned to Provider Relations in our St. Clairsville office. We maintain our providers’ attestation forms for verification of education in these areas to meet the requirements of the state and federal government.


In addition to CMS FWA and compliance training, we offer annual D-SNP training which is also a requirement of CMS. To view the training module for D-SNP visit healthplan.org/Content.aspx/d-snp-program.

We recommend verifying with your outside billing service or management firms if they also are including CMS FWA and compliance training as a basis of their seven core requirements for their compliance plan.

We will be tracking our network providers to insure all the required training has been completed. If you have already completed the CMS FWA and compliance annual training please submit the sign in sheet or proof you completed the CMS training. You are only required to complete the training annually and provide proof that you completed the training and the dates. All proof of FWA and compliance training is to be maintained for 10 years after termination of contract.

For additional information or assistance, please do not hesitate to contact Provider Relations or email hpecs@healthplan.org.
Laboratory Payments to Referring Physicians

Lab Services Reminder

On June 25, 2014 the Office of the Inspector General (OIG) issued an alert addressing compensation paid by laboratories to referring physicians and physician group practices for blood specimen collection, processing, and packaging, and for submitting patient data to a registry or database. In this alert, the OIG states that they have “repeatedly emphasized that providing free or below-market goods or services to a physician who is a source of referrals, or paying such a physician more than fair market value for his or her services, could constitute illegal renumeration under the anti-kickback statute.” Please be aware of these regulations and guidelines and address any agreements that you may have in place that could be in violation.

Behavioral Health to share with PCP

Patient Discharge Medication List

Behavioral Health Services is sending information to our member’s PCP when we are informed of an inpatient discharge. We are alerting the PCP to the discharge and sharing the medication list that has been provided by the hospital utilization review nurse. Due to HIPAA confidentiality provisions, no other information will be provided. Further coordination of care should take place on the provider level. A Release of Information form for the provider is available on The Health Plan website.

HealthCheck/EPSDT

Please continue to return these monthly lists to The Health Plan regarding your patients. We realize this is a very time-consuming task; however, the additional information you supply is extremely helpful. Examples include:

- When you say you are no longer the member’s PCP and often state who the new PCP is, we can correct our records.
- When you state that the member has been a no-show on certain specific dates, we can contact the parent/guardian to discuss this issue.
- When you state that the member was referred to a specialist, this is important as part of an EPSDT exam, and we can update our records.
- Please do not send the HealthCheck Appointment Sheet to us when it is not a Health Plan member. This is a HIPAA violation. You are not required to submit your office notes when you return these lists to The Health Plan.
Keeping Your Information Current
It is important to notify us of changes.

In this electronic age of direct deposit, electronic remittance advices and electronic submission of claims we may lose sight of remembering to notify The Health Plan of any changes.

It is important to notify us of any changes, such as a change in your physical location, telephone number, backup coverage, hospital affiliation and practice restrictions. All of this information is gathered in order to provide the most current information to our members in the form of directories, whether they are electronic or paper.

To ensure you are correctly listed in our directories, please take a minute to check the information on our website, healthplan.org.

Go to Solutions & Services, and select “Find a Provider,” from the dropdown menu.

In “Option 1,” click the search button. In Step 1 enter your last name only. In Step 2, select all providers and click the Submit button. Click on the appropriate underlined full name of the provider. Your provider detail information will display for you to review.

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The Health Plan • 52160 National Road East • St. Clairsville, OH 43950-9365 • 1.800.624.6961 • healthplan.org

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