The Health Plan is pleased to announce the WV Health Bridge membership (expansion population) is anticipated to be transitioned to Managed Care on July 1, 2015. All Health Bridge members who choose The Health Plan will be issued a Health Plan ID card in addition to their Medicaid ID card. The Health Plan will be offering all the services that are currently reimbursed by Medicaid for this expansion population.

The BH Medicaid Provider Manual with a complete explanation of this service, along with all others covered under the WV Health Bridge program will be available on our website prior to July 1, 2015.

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The Health Plan

WV Medicaid Transitioning Behavioral Health to MCOs

The Health Plan anticipates West Virginia Medicaid (BMS) will transition the administration of behavioral health benefits for the Mountain Health Trust (MHT) TANF population to the Managed Care Organizations (MCOs). The tentative transition date is July 1, 2015. If you currently provide behavioral health services and have a question(s) concerning your current contract with The Health Plan or you wish to contract or amend your current contract to be able to continue providing behavioral health services to these members, please contact The Health Plan Network Development Department at 1.800.624.6961, ext. 6248. The Health Plan will be offering all the services that are currently reimbursed by Medicaid. Additionally, The Health Plan will reimburse services provided by independent counselor/therapists.

We will also allow “bridge visits.” Bridge visits are follow-up appointments after inpatient hospitalization for behavioral health issues. This appointment is provided on the same day as discharge and can take place at the facility from which the member is being discharged; however, the appointment may not be held on the inpatient unit. The goal of the bridge appointment is to provide proper discharge planning and to establish a connection between the member and the outpatient provider. The entire BH Medicaid Provider Manual with a complete explanation of this service, along with all others covered under the MHT program will be available on our website.
Compliance
Fraud, waste and abuse

The Health Plan strives at being proactive by using education as a tool to ensure that our members receive the highest quality of care through you, the provider. The Compliance Department at The Health Plan is thus committed to furnishing periodic reminders and updates to providers on various compliance related subjects to facilitate our preventative approach in meeting this goal.

This quarter we would like to review The Health Plan’s expectations with regards to fraud, waste and abuse (FWA) training and retention of records, as well as the proper mechanisms for reporting instances of suspected FWA. We would also like to remind our providers of our shared responsibilities in performing due diligence of screening staff personnel via the appropriate government-regulated exclusion lists.

*For specific requirements, expectations and helpful links within these areas, please refer to our website at healthplan.org for the full article under the “Providers” page.

COMPLIANCE THROUGH TRAINING
The Health Plan maintains our provider’s attestation forms for verification of education in order to meet state and federal government requirements, and we will be tracking our network providers to ensure that all required training has been completed.

You are required to complete the FWA training on an annual basis, and provide proof that you have completed the training along with the date(s). If you have already completed the CMS FWA and compliance annual training, please submit the sign in sheet or other proof that the training has been completed. All proof of FWA and compliance training is to be maintained for 10 years after contract termination.

*Please see specific requirements and guidelines on our website under the “Providers” page.

COMPLIANCE THROUGH REPORTING
The Health Plan holds that it is the duty of every person who has knowledge or a good faith belief of a potential compliance issue to promptly report such an issue or concern upon discovery. This reporting obligation applies even if the individual with the information is not in a position to mitigate or resolve the potential problem. This obligation applies to all of The Health Plan’s First Tier, Downstream and Related entities (FDRs).

The Health Plan also believes that issues involving potential or actual instances of FWA can be investigated and remediated if an entity feels comfortable reporting such instances through their designated channels. There are various reporting mechanisms for use in confidentially reporting any compliance concerns or
suspected or actual misconduct for FWA. *Please see specific requirements and guidelines on our website under the “Providers” page.

“All proof of FWA and compliance training is to be maintained for 10 years after contract termination.”

COMPLIANCE THROUGH MONITORING
Federal law prohibits the payment by Medicare, Medicaid or any other federal health care program for an item or service furnished by a person or entity excluded from participation in these federal programs. As an MA organization and Part D sponsor, The Health Plan and its FDRs are thereby prohibited from contracting with or doing business with any person or entity that has been excluded from participation in these federal programs. Prior to hire and/or contract, and monthly thereafter, each first tier entity must perform a check to confirm its employees, governing body, volunteers and downstream entities performing administrative or health care services for The Health Plan’s Medicare lines of business are not excluded from participation in federally-funded health care programs according to the OIG, SAM exclusion list screening. *Please refer to the Provider page of our website for additional information and helpful links.

The Health Plan will continue to educate our providers with future reminders, bulletins and updates to further ensure compliance, and foster a continued long-standing relationship with all of our valued providers.

Thank you for your dedication and continued hard work towards satisfying the overall health care needs of our members.

REMINDER: CMS Annual Training Requirements

CMS requires documentation from our providers of the completion of the compliance training in FWA 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; 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 go to CMS MLN at: cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Waste_Abuse-Training_12_13_11.zip
Immunization Information

State Supplied Vaccine Requires the SL Modifier
As a reminder, when billing for immunizations you receive via the vaccine for children (VFC) program, you are required to use the SL modifier. The SL modifier needs to be added to the immunization code. If you do not participate with this program, you should refer your Mountain Health Trust members to another provider or to the local health department for their immunizations so that your claims are not denied. Since the state does provide the vaccine through the VFC program, The Health Plan will only reimburse for the administration of the vaccine.

Blood Lead Screening for Medicaid/MHT 2-year olds
A blood lead screen (CPT 83655) is required for all Medicaid/MHT children on or before their second birthday. This test can be ordered by a pediatrician or by the primary care physician.

For more information on this important test, visit wvdhhr.org/mch/lead/ScreeningPlan.pdf

For more information on the EPSDT periodicity schedule, visit wvdhhr.org/healthcheck

PCP and Pediatrician Use of the State Immunization Registry
Immunizations have protected millions of children from potentially deadly diseases and have saved thousands of lives. The Health Plan Preventive Health Guidelines include recommendations for childhood immunizations that follow the guidelines set forth by the American Academy of Family Physicians, the American Academy of Pediatrics, and the Advisory Committee on Immunization Practices.

In light of these recommendations, we encourage our primary care physicians and pediatricians to ensure that your patient’s childhood immunizations are up-to-date, recorded correctly in the chart, and entered on the State Immunization Registry. For more information on immunizations, visit immunize.org.

West Virginia:
wvsis.wvdhhr.org/wvsis/main.jsp
1.800.642.3634

Ohio:
odhgateway.odh.ohio.gov/impact/
1.866.349.0002

Quality Improvement Goals

The goal of the Quality Improvement Department is to improve medical outcomes and quality of service to our members. In order to identify issues, we routinely monitor inpatient and outpatient visits for any adverse events such as falls, post-op complications, unanticipated deaths, and readmissions within 24 hours. We also track PCP changes which occur when a member chooses another physician to provide their care.

Reasons often given for this change are after-hours accessibility issues, dissatisfaction with medical management, communication issues, and issues related to the physician office staff. If you or your patients have any questions or concerns about the care or service that they receive, we encourage you to call the Customer Service Department at 1.888.847.7902, 740.695.7902 or visit our website at healthplan.org.
COPD Disease Management Program

The chronic obstructive pulmonary disease (COPD) program is designed to modify risk factors associated with COPD as well as slow the progression of the disease. This is accomplished by promoting treatment plan compliance through education, counseling, and support. Program goals include:

- slowing the progression, or stabilization of symptoms of COPD
- optimization of functional capacity
- Improved quality of life
- reduction in frequency of exacerbations and hospitalizations
- promotion of pulmonary function testing
- facilitation and enhancement of the patient/doctor relationship

“The purpose of the COPD program is to empower the member...”

Program Content

Member identification is completed in a variety of ways including claims, health risk screening, member self referral or direct referral from the health care provider. Member stratification is based on severity of illness, hospitalization and emergency services utilization.

Primary attention is given to the evaluation of appropriate medication use (includes the HEDIS® measures of a systemic corticosteroid dispensed within 14 days of an event and a bronchodilator dispensed within 30 days of an event), education and counseling about daily self-management, and recognition of early COPD exacerbations.

High risk members receive telephonic disease management intervention from a COPD nurse specialist that includes the evaluation of appropriate medication use, education and counseling about daily self-management, and recognition of early signs and symptoms of exacerbation requiring intervention. Members also receive assistance with smoking cessation, nutrition, and obtaining referrals for home oxygen/respiratory therapy, or pulmonary rehabilitation. Consideration of other health conditions, such as diabetes, chronic heart failure, hypertension and hyperlipidemia are included in the management program. The COPD program starts with initial management of an acute exacerbation and continues with ongoing condition monitoring and surveillance, at intervals determined by the member and nurse specialist. A pharmacist is also available to assist with medication monitoring.

The purpose of the COPD program is to empower the member to communicate with their practitioner about their condition and treatment plan, and to compliment the medical care provided by the physician.

1HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).
Colorectal Cancer Screening
Remember the following guidelines.

Colorectal cancer is the third most common cancer in both men and women and the second leading cause of cancer-related deaths in the United States. When colon cancers are detected at an early stage, the five-year survival rate is 90 percent. When colorectal cancer is detected early, treatment cost is comparably low. Because screening rates are so low, only 39 percent of colorectal cancers are detected at this stage.

The National Colorectal Cancer RoundTable and the American Cancer Society have joined forces to promote “80% by 2018.”

“80 percent by 2018” is a National Colorectal RoundTable initiative in which dozens of organizations have committed to eliminating colorectal cancer as a major public health problem. They are working on reaching a goal of 80 percent of adults aged 50 and older screened for colorectal cancer by 2018.

Colorectal cancer is suffered among more than 140,000 adults diagnosed with colorectal cancer each year. When adults get screened for colorectal cancer, it can be detected at an early stage when treatment is more likely to be successful. In some cases, it can even be prevented through the detection and removal of precancerous polyps. About 1 in 3 adults between the ages of 50 and 75 years old, about 23 million people, are not getting tested as recommended.

Screenings can save lives but only if people get tested. There are several recommended screening test options, including colonoscopy, stool test (guaiac fecal occult blood test (FOBT), and sigmoidoscopy). Achieving an 80 percent screening rate by 2018 will require the collaboration of many leaders. Health care providers, health systems, communities, businesses, community health centers, government, and every day Americans all have a role to play. Dozens of groups, including the American Cancer Society, have pledged to work together to increase the nation’s colon cancer screening rates and embrace the goal of reaching 80 percent screened for colorectal cancer by 2018.

By working together, demanding more of ourselves, and collectively pushing harder toward this common goal, we will make greater progress, prevent more cancers, and save more lives than we would by acting alone.

To learn more about “80% by 2018” visit nccrt.org/about/80-percent-by-2018/. You can also sign your pledge.
Documents and access

Behavioral Health

Submitting Preauthorization Requests for Behavioral Health
All Health Plan behavioral health forms may be submitted electronically via the secure provider portal. Contact Provider Relations to set up access to the site.

Telehealth Services for Behavioral Health
Telehealth services will be paid to behavioral health practitioners when face-to-face services are not feasible. There is no special preauthorization process for telehealth. InterQual criteria must be met for the service. Services that are eligible for telehealth include, but are not limited to psychotherapy, pharmacological management, diagnostic interview, and neurobehavioral status exams.

Provider groups who are eligible to provide telehealth include licensed psychiatrists, psychiatric nurse practitioners, clinical nurse specialists, physician assistants, licensed clinical psychologists, licensed professional counselors and therapists, and clinical social workers.

For more information, go to healthplan.org.

Behavioral Health Email
Documents may be emailed directly to Behavioral Health Services at BehavioralHealthDocuments@healthplan.org. Any documentation that contains member information must be sent securely.

Billing Sick & Well Exams

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 symptoms 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.

2015 Practitioner Surveys

The annual Practitioner Satisfaction Survey will be mailed out soon. The survey mailing will include behavioral health practitioners and secondary care physicians, along with all primary care physicians.

Please take the time to complete this survey so our Medical Management Department can benefit from your opinion and suggestions to better serve you.

Your name will be on the survey tool as it has the past few years. It is our intent to be better able to follow-up on your complaints, concerns or issues when your name is on the form.

Any questions, please feel free to call the Medical Management Department at 740.695.3585 or 1.800.624.6961, ext. 7644 or 7643.

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. If you would like a copy please contact the provider relations customer service representatives at 1.740.695.7901 or call 1.800.624.6961, ext. 7901.
The Health Plan invites you and your staff to attend one of our provider seminars. The primary focus of the meetings will be the WV Medicaid Expansion and transition of behavioral health to the WV Managed Care Organizations (MCOs).

- Our morning sessions will provide information on our lines of business, specifically PEIA. It will also address the WV Medicaid Expansion Program, preauthorization and medical management, D-SNP program overview, ICD-10 coding, billing procedures, electronic capabilities and our quality improvement and HEDIS measures.

- Our afternoon sessions will provide you with information on behavioral health information and updates, the transition to the MCOs, WV Medicaid Expansion Program, preauthorization and medical management, our Medicaid Behavioral Health Provider Manual and information on billing and encounter codes.

Registration forms are available on our website: healthplan.org/providers/news-and-media/latest-news

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<td>Wheeling Park White Palace</td>
<td>1801 National Road</td>
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<td>Beni Kedem Shrine Center</td>
<td>100 Quarrier Street</td>
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<td>The Bridgeport Conference Center</td>
<td>300 Conference Center Way</td>
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