ProviderFocus

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Member ID Cards & Provider Networks

Always look for the logo on the front of the member ID card, which indicates if they use another provider network. The billing address is located on the back of the cards.

Inside this issue …

The Health Plan

The Health Plan

Notice: Please Update Your Records

Our Address Has Changed

We have a new mailing address! (This includes claims).
Please update your records.

If One of These Addresses:

The Health Plan
PO Box 4816
Massillon, OH 44647

The Health Plan
52160 National Road East
St. Clairsville, OH 43950

The Health Plan
PO Box 669
St. Clairsville, OH 43950

The Health Plan
52180 National Road East
St. Clairsville, OH 43950

Replace with This New Address:

The Health Plan
1110 Main Street
Wheeling, WV 26003

Thank you for your prompt attention to this matter. If you have additional questions, please feel free to contact Provider Relations at 1.877.847.7901.

Notice of Changes

Prior Authorization Requirements

Effective January 1, 2018, the following changes will be made to The Health Plan's pre-authorization/pre-notification requirements.

Deletions:

- Total joint arthroplasty performed in ambulatory surgical center

Pre-authorization notice of changes, lists and forms can be found at healthplan.org/preauth.

New to The Health Plan

Provider Analytics Program

The Health Plan is excited to announce the development of its provider analytics program. The provider analytics program uses CCGroup Marketbasket System™ analytical software, which builds episodes of care from claims data and ties them to specialty-specific medical conditions commonly seen in clinical practice. The episodes are analyzed for trends related to cost, utilization and adherence to evidence-based quality measures in order to create peer-to-peer physician comparative scorecards.

The first step is to provide historical data to primary care providers via a secure provider portal. Preliminary reports serve as a review of activity related to patient care and a comparative analysis using a specialty-specific peer group. Visit the provider portal to view a document explaining the CCGroup Marketbasket System™ methodology and information contained in the reports. The Health Plan will offer web-based educational seminars, with dates and times posted on The Health Plan website. Targeted initiatives include focused review of high-volume primary care providers, with comprehensive one-on-one discussion of CCGroup efficiency and effective reports.

The Health Plan's mission is to improve healthcare costs and quality. Sharing data is the initial step in preparing for future value-based reimbursement payment. Further information regarding our provider analytics program may be obtained by contacting Joy Juskowich, Medical Analytics Officer (jjuskowich@healthplan.org), or Brenda Cappellini, Director of Clinical Analytics and Technology Research (bcappellini@healthplan.org).

"Are We Gold-Carded?"

Regarding Pre-authorizations

Our customer service representatives are often asked this question. Our answer will soon change, but for good reasons.

Gold-carding was established during the 1990s as a way to lessen the pre-authorization burden for network physicians who had established a good record regarding pre-authorization and medical appropriateness review. This was because services like colonoscopies, mammograms, CTs, MRIs, and even cholecystectomies required pre-authorization. Throughout the years, services that were considered for "gold-carding" were audited, added and/or removed from THP pre-authorization requirements list.

Today, gold-carding specific services is essentially nonexistent, as all providers are held to comply with the same pre-authorization list. Therefore, the term "gold-carding" is no longer a meaningful designation. THP pre-authorization requirements list is updated based on industry standards, and as new technology, pharmaceuticals, etc., are introduced and validated through evidence-based practice and governing agencies.

THP pre-authorization list is now a document that is applied to all physicians and practitioners across all states and all lines of business, with some exceptions for THP self-funded employer groups. With the implementation of the provider analytics program, software with clinical intelligence will provide peer-to-peer comparison data in a way that can trend overall care, not just specific services.

Therefore, in 2018, the term "gold-card" will no longer apply to any physicians or practitioners, as all of the network will follow the requirements as established and outlined in the pre-authorization lists.

You can find the updated versions of both medical management and behavioral health pre-authorization requirements on The Health Plan's website.

Please contact The Health Plan if you have any questions.

Depression Disease Management Program

Treatment Support

From time to time, The Health Plan's depression disease management program will fax a request to your office for medication information and diagnosis confirmation. This information is very useful for us when speaking to the members in order to support your treatment plan.

If you have any questions or concerns, you can contact Karen Angelo, Nurse Navigator, by calling 1.800.624.6961, ext. 7621.

THP Behavioral Health Services Staff

Autism Advocate Added

The Health Plan's autism advocate is dedicated to assisting families who have a child who has been diagnosed with autism. Services provided by the autism advocate program consist of four essential components:

- Assessing the needs of the child and the family through completing a telephonic "autism intake."
- Providing individualized telephonic consultation tailored to support the needs of each child with autism, as well as the needs of the family. Consultation is provided by a certified early intervention specialist and includes discussing the child's health care benefits as well as any education and developmental concerns the family may have for the child.
- Providing evidence-based resources and information to families through their choice of email, mail or fax. Some sample topics include: advocacy, individual education programs (IEPs), parent and child rights in special education, medication and autism, applied behavior analysis (ABA) and other behavioral health treatments, managing behaviors and positive behavioral support.
- Linking families to community and state resources upon request.

To speak with an autism advocate, or to learn more about this service, contact Behavioral Health Services at 1.877.221.9295.

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.

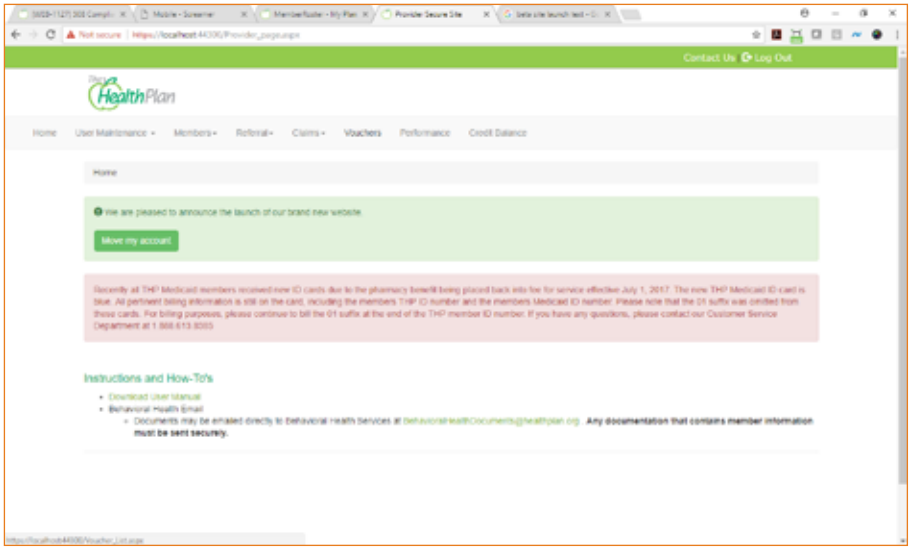
Member Rights & Responsibilities

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. If you would like a copy please contact Provider Relations Customer Service at 1.800.624.6961, ext. 7901.

New Secure Provider Website

New Provider Portal

We are pleased to announce the launch of our new secure provider website. With this new site, we have integrated enhanced security features to keep your information better-protected. We've also improved the website's functionality to allow for a more efficient and user-friendly experience. We hope you enjoy these enhanced features. We will be moving users from the old website to the new website in phases. After your account has been switched, you will see a green banner at the top of your screen notifying you of the change. You will be prompted to click "move my account" to get started on the new website!



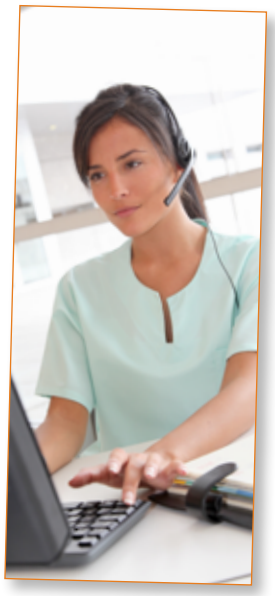
If you have any questions, please contact Customer Service at 1.877.847.7901.

Case Management Program

Help When You Need It

The Health Plan has registered nurses that are certified case managers to coordinate health care services for members with catastrophic illnesses, injuries or behavioral health problems. If you have a patient you believe would benefit from our case management program, you can contact the case managers by calling the Medical Department toll-free at 1.800.624.6961, ext. 7644 or 7643. Contact the Behavioral Health Services Department at 1.877.221.9295.

Visit healthplan.org to find detailed information regarding The Health Plan's Case Management Program, Behavioral Health Services and even an online physician case management referral form to easily refer one of your patients.



REMINDER: Prior Authorizations

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

Medicaid

Unlisted Procedure Code 41899

Dental providers are required to obtain prior authorization from Scion Dental for Medicaid members under the age of 21 who require dental services in a hospital setting. Once the provider obtains the prior authorization from Scion, the hospital services are required to be authorized through The Health Plan by calling the Customer Service Department. The authorization number from Scion will be required when requesting the authorization from THP.

For members over the age of 21, dental benefits are limited to emergency extractions only and require prior authorization. Please contact our Customer Service Department at 1.877.847.7901.

New Opioid Management Program

Implemented in November

As you are aware, prescription medications are an important part of improving the quality of life for millions of Americans living with pain. However, one of the most serious public health problems in our country is the over dependence on these medications, particularly prescription opioid pain medications.

Beginning November 1, 2017, The Health Plan will begin implementation of an opioid management program to help combat the growing abuse of opioids. This program will apply to commercial and select ASO clients only.

As a part of this program, we will be implementing the following changes to prescribing and dispensing of opioid medications:

- The first fill of an opioid medication for an opioid naïve patient will be limited to a five-day supply.
- Prior authorizations will be required for the following:
  1. Greater than 80 morphine milligram equivalents of opioids per day;
  2. Opioid usage greater than 90 consecutive days;
  3. Opioids used in combination with CNS depressants; and
  4. Long-acting opioid medications

For more information, contact our Pharmacy Services Department at 1.800.624.6961, ext. 7914.

Electronic Data Interchange (EDI)

New Auditing Software Coming Soon!

The Health Plan will soon be rolling out a new auditing software to assist with claims. This tool will support the front-end processing of claims, electronic remittance advice, claim rejections, eligibility, claims status and other EDI healthcare related transactions before going into or out of our system.

There are seven levels of edits, known as "SNIP," that incoming transactions must pass through before they are accepted for processing at The Health Plan or eligible for distribution to our trading partners. This tool uses HIPAA implementation guidance to provide best practices in the industry. We will soon be testing the new software with clearinghouses and other trading partners.

Hospital Discharge & Readmission

Help Us Help You

During discharge from a hospital, patients are typically focused on going home or to another site of care; they are often not emotionally prepared to comprehend detailed discharge instructions. Once patients get home and relax, they may not remember what they're supposed to do, which could lead to a trip back to the hospital.

Among Medicare patients, almost 20 percent who are discharged from a hospital are readmitted within 30 days, and the cost of readmissions is 15 to 20 billion dollars annually. Preventing readmissions has the potential to improve both the quality of life for patients and the financial well-being of health care systems.

We at The Health Plan coordinate care with our members and providers through telephonic discharge outreach assessments for all members that are admitted to the hospital. It is very beneficial when we have access to the members discharge instructions prior to the follow-up phone call to ensure they are following all directions and medication regimes set forth by the physician.

We ask all hospitals to fax us a copy of the member's discharge instructions when the patient is discharged so that we can review them with the member, answer any questions they may have, remind them of their upcoming follow-up appointments or procedures and coordinate care as needed.

You can fax this information to 1.888.329.8471. We appreciate your help with this initiative to lower readmission rates and improve care.

The Health Plan

Elective Admission Process

At the Health Plan, we require prior authorization for all elective admissions. Elective admission is listed under inpatient care on our prior authorization list which is posted on The Health Plan website.

Prior authorization ensures that the services requested by any particular provider at any facility are appropriate and covered under the member's individual benefit plan. Once the patient arrives at the hospital for the pre-authorized elective admission, our Utilization Department requires a phone call or faxed submission of admission demographics. We require this so we can place a census on file to ensure the patient stay is monitored for quality and length of stay and that any transitional needs can be coordinated by our team members collaboratively with the hospital staff administering services.

Once we receive admission demographics, your facility will be given a census number. The census number will be different than the prior authorization number. Continuous utilization review will be performed during the inpatient stay utilizing Interqual criteria to determine authorization of additional days as supported by your submission of clinical information. Continuing stay authorization may require submission of clinical data as often as every two days or as infrequently as weekly depending on the individual case scenario and facility contracts. Facilities will receive notification of "last covered day" and "next review due" with each update prior to final discharge dispensation and determination notice.

Providers should be aware that claims cannot be processed if there is not a census on file for all elective admissions, including those that were pre-authorized. Providers will receive a denial notification if claims are submitted prior to placing a census. Please contact The Health Plan's Medical Management Department for any questions regarding pre-authorization, utilization management or coordination of care by calling 1.800.624.6961.

Medical Management

Review Criteria

Nationally recognized clinical criteria are utilized to perform reviews for medical appropriateness allowing for consideration of the needs of the individual member, their circumstances, medical history and availability of care and services within The Heath 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 Medical 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 particular case. InterQual® review worksheets are available upon request.

Please indicate if your request is emergent so that we may expedite the review.

Simply scheduling the testing/ procedure does not warrant an expedited review. Unless an emergency, scheduling should be done after being approved by The Health Plan.

Secure Provider Website Set-Up

The Health Plan's secure provider website is available for registration of new users or groups. The new group's primary contact can register the group and will be responsible for maintaining their online staff. The website is accessible by our participating practitioner network. Currently available on our website:

- **Member eligibility**
- **Member rosters**
- **Referral status**
- **Referral submission – Only PCP to specialist**
- **Claim status**
- **Claim submission**

To register, please visit healthplan.org; select the provider tab, which drops down. Select provider secure website. The primary contact will receive an automated email with access status as well as a web application. Web applications are required for the initial registration and to add a new tax ID(s). The primary contact adding new users will not require a web application to be completed.

REMINDER: Signatures, Credentials & 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.

Identifying Low Income Patients

Low Income Medicare Beneficiaries

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.

If you are a primary care physician, 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 providers.healthplan.org. You can refer to this CMS MedLearn Matters article for further guidance: cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersARticles/downloads/SE1128.pdf

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

For more information, contact the Centers for Medicare Services at 1.800.MEDICARE (1.800.633.4227).

The Health Plan Medicaid Members

Enteral Nutrition Pre-authorization Requests

Managed Care Organizations (MCO) cover enteral nutrition for enrollees according to policies set forth by either the early periodic screening, diagnosis, and testing program (EPSDT), or the medical necessity criteria set by the MCO. You can find The Health Plan's coverage guideline for enteral nutrition is available on our website in the durable medical equipment policy information.

Requests for pre-authorization review of enteral nutrition should be called in directly to The Health Plan at 1.888.613.8385 or faxed to 1.888.329.8471.

The HealthPlan

1110 Main Street
Wheeling, WV 26003