



Provider Focus

A Publication of The Health Plan • November 2018

Inside this issue ...

Telehealth Services	2
Clinical Practice Guidelines	2
Fluoride Varnish Reimbursable	2
Overpayments and Offsetting	3
Medicare and Medicaid	3
REMINDER: CMS Annual Training Requirements	3
REMINDER: Signatures, Credentials and Dates Are Important	3
Hours of Operation Reminder to Providers	3
REMINDER: Prior Authorizations	3
Notice of Formulary Changes	4
Case Management Program	4
When Does THP Require a Census?	5
Continuity and Coordination of Care	5
The Health Plan Affirmative Statement	5
Discharge Instructions Required	6
Keeping Your Information Current	6
Denied Claim Resubmission	7
Webinars	7
ABN & Non-Covered Services to Medicare Advantage Members	7
Rheumatoid Arthritis Management	8
Collection of Venous Blood by Venipuncture	8
Member Rights and Responsibilities	8



Notice

Readmissions Review Occurring Within 30 Days

Attention Hospital Providers:

Effective November 1, 2018, all clinically-related readmissions occurring within a thirty (30) day period will be subject to review. Readmissions will be denied when any of the following are determined:

- A medical readmission for a continuation or recurrence of the previous admission or closely related condition (e.g., readmission for diabetes following initial admission for diabetes)
- A medical complication related to an acute medical complication related to care during the previous admission (e.g., patient discharged with urinary catheter readmitted for treatment of a urinary tract infection)
- An unplanned readmission for surgical procedure to address a continuation or recurrence of a problem causing the previous admission (e.g., readmitted for appendectomy following a previous admission for abdominal pain with fever)
- An unplanned readmission for a surgical procedure to address a complication resulting from care from the previous admission (e.g. readmission for drainage of a post-operative wound abscess following an admission for bowel resection)

Hospital readmission review determination as described above is specifically to determine if the readmission is clinically related and is not an assessment of medical necessity or appropriateness of setting. In the absence of information to determine the appropriateness of the readmission, clinically-related readmissions within a thirty-day period will be automatically denied and the provider will need to submit medical documentation to support the need for payment. Final review decisions will be determined by one of The Health Plan's medical directors. This guideline is available upon request. Questions regarding claim denials may be directed to The Health Plan at 1.877.847.7901.



Telehealth Services

Access to Healthcare

Effective August 28, 2018, preauthorization is no longer needed for telehealth services. The Health Plan follows Medicare criteria for telehealth services for all lines of business, with the exception of our WV Medicaid product line which adheres to WV BMS policies.

Telehealth services will be paid to behavioral health practitioners/providers when face-to-face services are not feasible. A need for telehealth services must be demonstrated. Examples of this need include, but are not limited to geographic restrictions, financial difficulties, limited mobility, transportation issues and limited access to service.

Telehealth services must be conducted through the use of an interactive audio and video telecommunications system that permits real-time communications between the practitioners/providers at a distant site and the member at the originating site. The telecommunication equipment must adequately complete all necessary components to document the level of service for the CPT or HCPCS codes to be billed. The equipment utilized must be HIPAA compliant and meet current Medicare and WV Medicaid standards.



Available Online

Clinical Practice Guidelines

The Health Plan and participating practitioners review and update the preventive health guidelines and clinical practice guidelines. We encourage you to use these guidelines as a reference tool to assist in planning your patients' care. To help make the information more accessible and convenient for you, we've posted a

complete set of guidelines online. Just visit healthplan.org/providers/quality-measures to view standards, guidelines and program descriptions for quality improvement, disease management and behavioral health practice guidelines.

Fluoride Varnish Reimbursable

Medicaid Members

Fluoride varnish is reimbursable for both medical and dental providers when administered to THP Medicaid members. Fluoride varnish may be billed two times per year for each type of provider for a total of four fluoride varnish treatments per year per member. The patient must be less than 21 years old. The procedure code may only be billed once within a six month period per medical and dental provider.

Medical Providers that apply fluoride varnish would bill procedure code 99188. Varnish must be applied during the time of a well-child visit or health screening. An oral health risk assessment should be conducted prior to application of the varnish.

Dental Providers applying fluoride varnish should bill procedure code D1206. The varnish should be applied during a dental visit.

When dentists apply a topical application of fluoride (this excludes fluoride varnish) they would bill procedure code D1208. Procedure code D1206 may not be billed in conjunction with procedure code D1208.



Resolutions Appeals and Recouping Overpayments Overpayments & Offsetting

Overpayments can be identified by either the provider or The Health Plan. Providers who identify an overpayment can submit a refund check with an explanation of the refund/payment to The Health Plan or call our Funds Recovery Department at 1.800.624.6961 to speak with a representative to approve a recoupment from any future payments to the provider.

If The Health Plan identifies an overpayment, the provider will be informed of any overpayments or other payments owed within 365 days of the date of the claim payment or within the timeframe noted in your provider agreement. You will have 40 days to notify us

of your intent to pay or appeal the overpayment determination. If you have not refunded us within 40 days, we will offset the recovery amounts identified in the initial notification against your next payment voucher, or in accordance with the terms of your provider agreement unless an appeal or refund is received. Resolution of appeals and collection of overpayments subject to appeal will be conducted in accordance with your provider agreement or applicable state law. Payments should be sent to:

The Health Plan
Attn: Funds Recovery Department
1110 Main Street
Wheeling, WV 26003

Medicare and Medicaid

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 coinsurance, 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 healthplan.org/providers.

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 or be charged for Medicare deductibles, coinsurance and copayments.

REMINDER: CMS Annual Training Requirements

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.

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.

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.

REMINDER: Prior Authorizations

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

REMINDER: Availability and Accessibility

Please note that in 2019 THPs appointment availability and after hours accessibility guidelines will apply to both PCPs and specialists.

Changes Take Effect January 1, 2019

Notice of Formulary Changes



Our formulary is revised annually by an independent national panel of health professionals with the goal of ensuring that patients receive the right drug at right cost. Beginning January 1, 2019 our formulary will exclude 48 new medications which affects approximately less than 0.2% of The Health Plan's overall membership.

The Health Plan will be notifying prescribers and members 60 days prior to formulary changes taking effect so they can take action to avoid paying full price for their medication.

EXCLUSION MEDICATIONS					
Alcortin A	Chorionic Gonadotropin	Emadine	Fml Forte, FML S.O.P	Neupro	Topicort Spray
Alocril	Climara Pro	Embeda	Humatrope	Pradaxa	Verdeso
Alomide	Contrave ER	Extaia	Lupron Depot-PED	Pred Mild	Xadago
Altoprev	Cortiform	Fenoprofen cap.	Mavyret	Pregnyl	Xerese
Atripia	Duzallo	Fenortho	Maxidex	Recombinate	Xyntha, Xyntha Solofuse
Berinert	Eloctate	Flarex	Nalfon	Savaysa	Zurampic
Brovana					

PREFERRED TO NON-PREFERRED CHANGES – MEDICATIONS MOVING TO A HIGHER COST SHARING TIER					
Acthar H.P.	Elelyso	Lemtrada	Oxsofalen	Technivie	Viekira, Viekira XR
Adcirca	Emend Powder Packet	Lucentis	Potiga	Temazepam	VPRIV
Arcalyst	Gardasil	Natazia	Renflexis	Vaqta vial	Zavesca
Cervarix	Inflectra	Oxazepam	Sivextro vial	Ventavis	Zostavax

BRAND-FOR-GENERIC SUBSTITUTION			
<i>Dispensing branded medications in situations where the generic equivalent is more expensive.</i>			
Covered brands	Excluded generic	Covered brands	Excluded generic
Adderall Xr	Dextroamphetamine/amphetamine	Lialda	mesalamine
Concerta	Methylphenidate ER	Welchol	Colesevelam hcl
Estrace 0.01%	Estradiol 0.01%	Uceris	Budesonide

Case Management Program

Here to Help

The Health Plan has a team of registered nurse case managers who coordinate health care services for members with catastrophic illnesses, injuries or behavioral health problems. If you have a patient you believe would benefit from the case management program, contact our Medical Department at 1.800.624.6961, ext. 7644 or 7643 or Behavioral Health Services Department at 1.877.221.9295.

The Health Plan's website, healthplan.org provides detailed information about our case management program, Behavioral Health Services Department, and even provides an online Physician Case Management Referral Form to easily refer one of your patients.

Important Information for Processing Claims

When Does THP Require a Census?



The Health Plan assigns a census number for the following medical services:

- all in-network and out-of-network/out-of-area elective and urgent/emergent inpatient admissions to a hospital
- skilled nursing facility
- rehabilitation inpatient care
- acute care
- long-term acute care facility (LTACF).

Notification of urgent/emergent inpatient admissions is expected within 48 hours to in-network facilities. Notification is available 24/7 by calling 1.800.304.9101 or faxing 1.888.329.8471 for medical services.

A census number is assigned for the following behavioral health services:

- all in-network and out-of-network/out-of-area behavioral health elective and urgent/emergent inpatient admissions to a hospital
- substance abuse rehabilitation center
- crisis stabilization unit (CSU) observation
- intensive outpatient program (IOP) for non-governmental programs and partial hospitalization.

Notification of urgent/emergent inpatient admissions is expected within 48 hours to in-network facilities. Notification is available 24/7 by calling 1.877.221.9295, faxing 1.866.616.6255 or via

the secure provider portal at myplan.healthplan.org/Forms/AdmissionReviewInformation.

When admission demographics and clinicals are received, the hospital will then be given a census number. The census number is different than the pre-authorization number.

Claims cannot be processed if there is no census on file for ALL elective admissions including those that were pre-authorized.

The Health Plan requires the following discharge information: date, follow-up care and medications. Failure to obtain a census number and providing discharge information will result in a denied claim.

Continuity and Coordination of Care

Between Behavioral Health Care and Primary Care Practitioners

Continuity and coordination of care between behavioral and physical health care providers is an important aspect in the delivery of quality health care. All federal and state confidentiality laws must be followed. The Health Plan expects that this information be shared accordingly and recognizes the right to keep progress

notes private. The Health Plan also understands that there are special situations where information cannot be shared. More information on continuity of care, including a consultation sheet is available on The Health Plan's website for use in facilitating this communication at healthplan.org.

Regarding Incentives August 2018

The Health Plan Affirmative Statement

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, nor does The Health Plan condone under-utilization, nor inappropriate restrictions of healthcare services.

Preventing Readmission

Discharge Instructions Required

The Health Plan coordinates post-discharge care for members after an inpatient admission. In an effort to enhance this care and prevent readmission, The Health Plan requires that a facility's discharge instructions are provided to both the member and The Health Plan.

The goal is not to inconvenience the facility, but rather to help reinforce treatment plans, assist with medication reconciliation and act as the member's liaison, which are high priorities from all care perspectives.

Please assist The Health Plan nurse navigators when they reach out during the inpatient stay or immediately following discharge to request the member's discharge instructions. Discharge instructions may be faxed to Attention: Hospital Review at 330.830.4397. Be sure to include the member/patient's census number in the subject line of the fax cover page.

Keeping Your Information Current

Important Reminder

In the electronic age of direct deposit, electronic remittance advices and electronic claims submissions, it's important to notify The Health Plan of any changes to ensure you receive this information. Please be sure to notify us of any changes, such as a change in your physical location, telephone number, back up 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 follow these simple steps and check the information:

1. Visit our website, healthplan.org
2. Select Find a Provider
3. Under Commercial Member, click "search online"
4. Under "Step 1," enter your last name only,
5. Under "Step 2" select "All" and click "search."
6. Click on your practice/facility's name to view full details. Review all information to verify that it is still current.

Anyone (e.g., employee, volunteer, provider, member, Board of Directors) can report suspected fraud or issues of noncompliance.

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.

Please do not remove unless compliance department is notified

Resubmitting Electronic or Paper Claims

Denied Claim Resubmission

You may resubmit a claim either on paper or electronically through your clearinghouse. When resubmitting a claim on paper, please include the following:

- A completed new CMS 1500 form
- Attach a copy of the payment voucher with the member circled or underlined that you are resubmitting a claim for
- A clear explanation and/or additional documentation as to why the claim is being re-submitted
- Indicate on the claim form "corrected claim" or "resubmitted claim"

Mail corrected paper claims to:
The Health Plan
1110 Main Street
Wheeling, WV 26003

To resubmit a claim electronically through a clearinghouse:

- Use Reason code "6" in claim information 2300 Loop Segment CLM05 to indicate a corrected claim
- Use "7" in claim information 2300 Loop Segment CLM05 to indicate a replacement claim.
- If you wish to void a claim, use "8" in claim information 2300 Loop Segment CLM05
- Please Indicate the original claim number in the free text field

Failure to follow the resubmission guidelines could result in a claim being denied as a duplicate

If you have questions, please contact Provider Relations at 1.877.847.7901 for assistance on why a claim denied and how to resubmit your claim.

Webinars

Introduction to The Health Plan Recorded Webinar

New providers or those who would want a refresher course may view a recorded webinar on an



Introduction to The Health Plan by copying and pasting this link into your web browser: [https://](https://attendeegotowebinar.com/recording/8140642648643834371)

attendeegotowebinar.com/recording/8140642648643834371

RFTS Recorded Webinar

Are you a Right From The Start (RFTS) provider? You can view a webinar on RFTS-covered services and billing limits by copying and pasting this link into your web browser: <https://attendeegotowebinar.com/recording/2442569872737248515>. A list of Frequently Asked Questions (FAQs) may be accessed on The Health Plan's website at <https://myplan.healthplan.org/Account/Login>.

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.



ABN & Non-Covered Services to Medicare Advantage Members

As a reminder, Advance Beneficiary Notice of Noncoverage (ABN) forms may not be used for Medicare Advantage members to collect payment for noncovered services from the member.

Reminder: Patient Care

To avoid errors in patient care, medication reconciliation is required within 30 days of an inpatient admission.

Also, all specialists are held to the same standard for coordination of care with a member's PCP.



Rheumatoid Arthritis Management

Claim Validations



While the prevalence of Rheumatoid Arthritis (RA) is approximately one percent of all adults, RA patients require a significant investment in decision-making, patient education, and follow-up. According to the American College of Rheumatology guidelines and clinical practice standards, patients with RA require initiation of disease-modifying antirheumatic drug (DMARD) therapy within three months of diagnosis. Therefore, it is critical that your documentation, management, and reporting is accurate.

In an effort to improve member outcomes, The Health Plan will require diagnosis validation for SecureCare Medicare populations. When a medical claim with a

diagnosis of rheumatoid arthritis is submitted, the claim will reject until the claim is validated. Validating should involve submission of diagnostic workup such as blood tests (ESR, CRP, rheumatoid factor, anti-CCP, etc.) and imaging tests (X-rays, MRI, ultrasound tests, etc.). In most instances validation of rheumatoid arthritis claims should be directed from the member's rheumatologist. Claim validation has become necessary due to diagnosis discrepancies across members' treating physicians. We appreciate your attention to this matter and look forward to helping make this transition as smooth as possible. If you have any questions please call The Health Plan for more information.

Medicaid Members

Collection of Venous Blood by Venipuncture

For Medicaid members The Health Plan follows Bureau for Medical Services' (BMS) guidelines regarding reimbursement for collection of specimens and specimen collection fees. CPT code 36415 (collection of venous blood by venipuncture) is not separately reimbursable when the same provider is collecting the specimen and processing the specimen. The collection of the specimen is considered an inherent part of processing the specimen.

A specimen collection fee can be separately reimbursed if the specimen is collected in an office or laboratory but is processed elsewhere. When a specimen is drawn and sent to a reference lab for processing, The Health Plan will reimburse the referring provider for the specimen collection and the reference lab for processing the specimen. The reference lab must be contracted with The Health Plan for reimbursement of services rendered.

Only one collection fee is allowed for each type of specimen (e.g., blood, urine) for each member encounter, regardless of the number of specimens drawn. When a series of specimens is required to complete a single test (e.g., glucose tolerance test), the series is treated as a single encounter.

Please refer to BMS Manual Chapter 529 Labs at dhhr.wv.gov for more information.

For information regarding specimen collection of homebound members please refer to Chapter 508, Home Health Services.



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