# Table of Contents

## Section 1 - Welcome

- Introduction .................................................................................................................. 2  
- About Us ....................................................................................................................... 3  
- Mission Statement ........................................................................................................ 4  
- Network Services Contacts .......................................................................................... 5  
- Provider Quick Reference Guide .................................................................................. 8  

## Section 2 – Physician Availability

- Physician Availability ................................................................................................... 11  
- Primary Care Physician Guidelines ................................................................................ 12  
- PCPs Encouraged to Screen for Behavioral Health Needs ............................................ 13  
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment ........... 13  
- Secondary Care Physician Guidelines .......................................................................... 14  
- Specialist Guidelines ................................................................................................... 15  
- Physician Care of Self or Family .................................................................................. 16  

## Section 3 – Member Benefits

- Member Benefits ........................................................................................................... 18  
- Product Matrix .............................................................................................................. 19  
- Commercial HMO Plans .............................................................................................. 20  
- Commercial POS Plans ............................................................................................... 20  
- Commercial PPO Plans ............................................................................................... 21  
- Sample Commercial ID Card ....................................................................................... 22  
- SecureCare HMO Medicare Advantage Plan ............................................................... 23  
- SecureChoice PPO Medicare Advantage Plan ............................................................. 23
## Table of Contents

D-SNP Program (Medicare Advantage Special Needs Plan) ............................................. 24  
Sample Medicare ID Card .......................................................................................... 25  
Mountain Health Trust and West Virginia Health Bridge (WV Medicaid Program) ........ 26  
Sample Medicaid ID Card .......................................................................................... 26  
Administrative Services Only (ASO) Self-Funded Employer Groups ......................... 27  
Sample Self-Funded ID Card .................................................................................... 27  
Vision Service Benefit ............................................................................................... 28  
Sample Vision Provider Reimbursement Voucher ..................................................... 29  
The Health Plan’s Members’ Rights and Responsibilities Statement .......................... 30  
The Health Plan’s Members’ Anti-Discrimination Statement .................................... 32  

### Section 4 – Medicare

SecureCare HMO Medicare Advantage Plan ............................................................... 34  
SecureChoice PPO Medicare Advantage Plan ........................................................... 35  
D-SNP Medicare Advantage Special Needs Plan ....................................................... 36  
Coordination of Benefits Medicare Advantage Secondary Payer ............................... 38  
THP Insurance Company Medicare Supplemental Plans .......................................... 38  
Medicare Noncovered Service Guidelines ................................................................ 38  
CMS Quality Measures/Standards ............................................................................ 40  
Appointment of Representative Statement for a Medicare Member ......................... 41  
Appointment of Representative Forms ....................................................................... 41  
Notice of Medicare Noncoverage (NOMNC) ............................................................ 42  
Medicare Outpatient Observation Notice (MOON) ................................................... 43  
Medicare Appeals Overview ..................................................................................... 44  
Notice of Medicare Hospital Discharge Appeals Notices ......................................... 45  
Low Income Medicare Beneficiaries .......................................................................... 46  

TheHealthPlan
Medicare Provider Rights and Responsibilities ................................................................. 47
SecureCare/SecureChoice Rights and Responsibilities Statement ................................ 49

Section 5 – Medicaid

Mountain Health Trust (MHT) and West Virginia Health Bridge (WVHB) ........................................ 58
Mountain Health Trust ID Cards ......................................................................................... 60
WV Health Bridge ID Cards ................................................................................................. 61
Medicaid Benefits and Exclusions at a Glance ....................................................................... 62
Additional Resources for Medicaid Members ......................................................................... 70
Hours of Operation .................................................................................................................. 71
Cultural Competence ............................................................................................................ 71
EPSDT ..................................................................................................................................... 71
Copays ................................................................................................................................... 73
Medicaid Out-of-Network Non-Patient Facing Provider Reimbursement ............................. 74
Prescription Benefit ............................................................................................................... 75
Family Planning ..................................................................................................................... 75
Local Health Departments ................................................................................................... 76
Staffing .................................................................................................................................. 76
Surgical Consent Forms ........................................................................................................ 77
Pregnancy and Newborn Enrollment ....................................................................................... 78
Women’s Access to Health Care ............................................................................................ 79
Tobacco Cessation .................................................................................................................. 79
Diabetes ..................................................................................................................................... 79
Medicaid Behavioral Health Services ...................................................................................... 80
Medicaid Behavioral Health Credentialing and Billing Guidelines ........................................ 95
<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Dental</td>
<td>98</td>
</tr>
<tr>
<td>Children’s Dental</td>
<td>100</td>
</tr>
<tr>
<td>Immunization Registry</td>
<td>101</td>
</tr>
<tr>
<td>Appeals and Grievances</td>
<td>101</td>
</tr>
<tr>
<td>MHT/WVHB Members’ Rights and Responsibilities Statement</td>
<td>105</td>
</tr>
<tr>
<td>Medicaid Members’ Rights and Responsibilities Statement</td>
<td>109</td>
</tr>
<tr>
<td>Provider Reporting Requirements</td>
<td>112</td>
</tr>
<tr>
<td>Provider Responsibilities and Reimbursement</td>
<td>113</td>
</tr>
<tr>
<td>Changes to Provider Fee Schedules</td>
<td>114</td>
</tr>
<tr>
<td>Alternative Payment Models</td>
<td>115</td>
</tr>
<tr>
<td>Marketing Guidelines</td>
<td>116</td>
</tr>
<tr>
<td>West Virginia Medicaid Provider Required Provisions</td>
<td>119</td>
</tr>
<tr>
<td>Drug Testing Policy</td>
<td>125</td>
</tr>
<tr>
<td>Breathalyzer Testing</td>
<td>125</td>
</tr>
<tr>
<td>Transplant</td>
<td>126</td>
</tr>
<tr>
<td>Non-Par Provider</td>
<td>126</td>
</tr>
<tr>
<td>Prior Authorization</td>
<td>126</td>
</tr>
<tr>
<td>Chiropractic Service</td>
<td>126</td>
</tr>
<tr>
<td>Physical and Occupational Therapy</td>
<td>126</td>
</tr>
<tr>
<td>Inpatient Claims</td>
<td>126</td>
</tr>
<tr>
<td>NCD Rebate Eligible Drugs</td>
<td>127</td>
</tr>
<tr>
<td>Readmissions Review Occurring Within 30 Days</td>
<td>128</td>
</tr>
<tr>
<td>SUD Provider Training and Education Requirements</td>
<td>129</td>
</tr>
<tr>
<td>ER All-Inclusive</td>
<td>129</td>
</tr>
<tr>
<td>Outpatient Services for Acute and Critical Access Hospitals</td>
<td>130</td>
</tr>
</tbody>
</table>
Table of Contents

Paper Claim Submissions ........................................................................................................ 130
Medicaid Value Add Brochure ............................................................................................. 131

Section 6 – Office Copays, Medical Copays, Co-insurance & Deductibles

Office Visit Copays, Medical Copays, Co-insurance & Deductibles .................................. 134
Quick Reference Guide of CPT Codes for Office Encounters .............................................. 136

Section 7 – Clinical Services

Clinical Services Introduction ................................................................................................. 138
Medical Prior Authorization and Notification Requirements .................................................. 138
Palladian Health ....................................................................................................................... 139
eviCore healthcare .................................................................................................................. 140
Telephone Directory ............................................................................................................... 141
Nurse Information Line .......................................................................................................... 142
Admissions/Concurrent Review Process ................................................................................ 142
Prior Authorization/Referral Management Review Criteria .................................................. 145
InterQual® Criteria ................................................................................................................ 145
Requests for Second Opinion ............................................................................................... 147
Specialist Coordination of Health Care Services ................................................................. 148
Member Health and Wellness Promotion .............................................................................. 149
Ongoing Educational Materials ............................................................................................ 150
Care Navigation ....................................................................................................................... 151
Complex Case Navigation ..................................................................................................... 153
Social Work Services ............................................................................................................. 156
Chronic Disease Navigation Programs .................................................................................. 157
Diabetes Program .................................................................................................................... 159
Adult BMI Chart .................................................................................................................... 160
## Table of Contents

Chronic Cardiac Conditions Programs ................................................................. 161
Chronic Obstructive Pulmonary Disease Program ............................................. 163
Perinatal Care Program ...................................................................................... 165
Advance Care Planning ....................................................................................... 167
Leadership and Committees ............................................................................. 168
Annual Program Evaluation .............................................................................. 171
Forms, Tools and Worksheets ............................................................................ 171

### Section 8 – Population Health

Population Health Management .......................................................................... 173
Provider Analytics Program ................................................................................ 175
HEDIS® and HEDIS Measures and Coding Guide .............................................. 176
Dilated Fundus Exam Form .................................................................................. 177

### Section 9 – Quality Improvement

Introduction ........................................................................................................... 179
Quality of Clinical Care Indicators ...................................................................... 180
Customer Satisfaction Quality Indicators .............................................................. 180
Review Process for Clinical and Customer Service Quality Indicators .............. 181
Continuity and Coordination of Care ................................................................... 182
Standards for Access to Care and Services ......................................................... 183

### Section 10 – Behavioral Health

Introduction ........................................................................................................... 186
Review Criteria ..................................................................................................... 187
InterQual® Review ............................................................................................... 187
Behavioral Health Prior Authorization and Notification Requirements ............ 187
Table of Contents

Review of Inpatient Treatment, Detoxification, Rehabilitation of Substance Use Disorders and Observation................................................................................................................. 188
Outpatient Prior Authorization and Referral Management ................................................................. 191
Drug Screening and Testing.................................................................................................................. 195
Credentialing and Billing ................................................................................................................... 196
Annual Program Evaluation .............................................................................................................. 198
Access to Care .................................................................................................................................. 198
Continuity and Coordination of Care ............................................................................................... 199
Behavioral Health Services Forms .................................................................................................. 200
Telehealth Services ........................................................................................................................... 201
Follow-Up Care After Behavioral Health Admissions ........................................................................ 201
Standards and Guidelines of Care ..................................................................................................... 202

Section 11 – Pharmacy Services

Introduction.......................................................................................................................................... 204
Obtaining a Prescription ..................................................................................................................... 207
Pharmacy Prior Authorization and Notification Requirements ...................................................... 208
Formulary .......................................................................................................................................... 209
Prior Authorizations ........................................................................................................................ 211
Prior Authorization Forms ............................................................................................................... 212

Section 12 – Billing

Billing Procedures.............................................................................................................................. 214
Never Events and Avoidable Hospital Conditions .............................................................................. 217
Electronic Billing – Documentation Submission .............................................................................. 220
Fax Cover Sheet to Support Electronic Claim Submission ................................................................. 220
Credit Balance Explanation............................................................................................................... 221
# Table of Contents

- Reimbursement Voucher Example – Tracking Credit Balance ........................................... 221
- Notice of Readmissions Review Occurring Within 30 Days ........................................... 222

## Section 13 – EDI

- Introduction .................................................................................................................. 224
- Trading Partner Electronic Submitters ........................................................................... 225

## Section 14 – Coordination of Benefits (COB)

- Coordination of Benefits .............................................................................................. 227
- WV Medicaid Members ................................................................................................. 227
- Order of Benefit Determination Rules .......................................................................... 228
- Procedures Regarding COB ......................................................................................... 229
- Medicare Crossover Notice ............................................................................................ 230
- Medicare Primary ........................................................................................................ 231
- Commercial Credit Adjustment Example ....................................................................... 232
- Medicare Primary Payment Example .............................................................................. 233
- Helpful Hints ................................................................................................................ 234
- COB Denial Codes ......................................................................................................... 235

## Section 15 – Payment Voucher and Claims

- Payment Voucher Introduction .................................................................................... 237
- Sample Reimbursement Voucher ................................................................................... 237
- Claim Numbers ............................................................................................................. 238
- Age of Claim Determination ......................................................................................... 238
- Claims in Process .......................................................................................................... 239
- Resubmission of Claims Denied for Documentation ..................................................... 239
- Process to Resubmit a Denied Claim ............................................................................. 241
- Claim Resubmission Form ............................................................................................. 241
## Table of Contents

Perpetual Julian Date Calendar ........................................................................................................... 242
Overpayments and Offsetting ............................................................................................................. 243

### Section 16 – Credentialing

Credentialing ...................................................................................................................................... 245
Recredentialing ................................................................................................................................. 246
Practitioner’s Credentialing/Recredentialing Rights ....................................................................... 247
Office Orientation and Medical Site Survey Form ........................................................................... 249
Office Orientation and Behavioral Health Site Survey Form ........................................................... 249
Standards for Participation ............................................................................................................... 250
Initial Certification ............................................................................................................................. 254
The Health Plan Standards for Patient Records ............................................................................... 255
Medical Records and Confidentiality Statement .............................................................................. 259
Office Procedure Review .................................................................................................................. 260
Signature Log Form ............................................................................................................................ 260
Telephone Message Form ................................................................................................................... 260

### Section 17 – Phone Directory

Phone Directory ................................................................................................................................. 262

### Section 18 – Compliance, SIU and FWA

Fraud, Waste and Abuse Regulations and Guidelines ...................................................................... 264
Special Investigations Unit ................................................................................................................. 266
Compliance Through Training ........................................................................................................... 268
Compliance Through Reporting ......................................................................................................... 269
FWA Hotline Poster .......................................................................................................................... 269
HIPAA Privacy and Security ............................................................................................................. 272
Section 1

Welcome
Introduction

Respect for our members, respect for our providers, and respect for our clients.

At The Health Plan, our strong relationships with the communities we serve are driven by respect for the people who reside in our service areas.

Paramount in our core values is our commitment to advancing the quality of care delivered by our providers and received by our members using the best available practices.

As a provider, there are TWO important concepts to understand about The Health Plan:

The first concept is that of the personal physician. Members enrolled in our HMO and POS products are required to select a primary care physician (PCP), who act as the coordinator of care for the patient. Members must contact their PCP prior to making appointments with specialty providers. Upon assessment of the patient needs, the PCP may find it appropriate to refer the patient to other participating specialty providers.

The second concept pertains to that of an established network. The Health Plan contracts with providers in order to obtain quality care at an affordable price. This enables us to contain premium increases to our membership. All services that can be properly performed by plan providers must be referred in-plan. Services which are not available through this in-plan network require preauthorization via an out-of-plan referral.

In an effort to provide better access to services, The Health Plan has established contracts with out-of-plan providers. This is known as the tertiary network. Should a member of The Health Plan require specialty of care or services not available through the in-plan network of providers, then his/her physician will refer him/her to one of the participating tertiary providers. These are still considered out-of-plan referrals requiring preauthorization. These are discussed in greater detail in the pertinent section of the manual.

The purpose of this manual is to give you an overview of The Health Plan and its structure so that you can function more effectively as a provider.

In addition to this manual and the training that accompanies it, The Health Plan customer service representatives are always available to assist in any way possible by calling 1.800.624.6961.
About Us

The Health Plan was established in 1979 through provisions under the federal HMO Act. As a federally qualified and state-certified, 501(c)(4) not-for-profit HMO, our goal is to provide high quality, comprehensive and cost-effective health care. The Health Plan is West Virginia’s first and largest HMO, with a service area encompassing all 55 counties in West Virginia and 36 counties in Ohio.

We have a strong, regional plan with a distinct, local market focus.

At The Health Plan, we take pride in the communities we serve and our not-for-profit status. For over 40 years, we have been able to develop new lines of business and expand our markets.

This strategy has led to consistent, steady growth for The Health Plan, with over 200,000 members enrolled across our diverse product lines. Many THP members are enrolled through their employers, state Medicaid and Medicare Advantage plans.

Being one of the most financially stable managed care organizations in the region has been a key to The Health Plan’s success. Our financial strength allows us to put customer care over corporate profits by using over 90 cents of every health care premium dollar to pay claims for our insured members. The remainder is used to cover administrative overhead and any surplus at the end of the year is invested as equity and reserved for the protection of our members.

The Health Plan offers a complete line of managed care products and services designed to provide clients with innovative health care benefits at a reasonable cost. These include:

- Fully-Insured Health Maintenance Organization (HMO)
- Fully-Insured Preferred Provider Organization (PPO)
- Fully-Insured Point-of-Service (POS)
- Self-Funded Health Plans (HMO, MEWA, POS, PPO)
- Consumer Driven Services, including HRA, HSA and FSA Administration and COBRA Administration
- Competitive Stop Loss Coverage
- Benefits Administration
- Short-Term Disability Administration
- Pharmacy Benefit Management
- Vision and Dental Programs
- West Virginia Medicaid
- SecureCare (HMO) and SecureChoice (PPO) Medicare Advantage Plans
- SecureCare Dual-Eligible Special Needs Plan (D-SNP)
- Medicare Supplement
Mission Statement

“Established as a community health organization, The Health Plan 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 our community.”

In keeping with our mission, we have identified members’ rights along with their responsibilities, which are clearly indicated in the member’s handbook.

As a participating provider with The Health Plan, it is imperative that you be aware of these rights and responsibilities. You are expected to assist our members by making them aware of their rights and by supporting these within your practice.
Network Services Contacts

When calling for assistance, please reference the contacts below. Our hours of operation are 8:00 am to 5:00 pm EST Monday through Friday. Please submit all claims and correspondence to: 1110 Main Street, Wheeling WV 26003-2704

Provider Delivery Services

Antoinette Geyer—Senior Vice President, Provider Delivery Services
Email: ageyer@healthplan.org

Provider Contracting
Responsibilities - New contracts, amendments, contract changes (i.e. ownership, name or TIN change.)

Deloris Barrett—Director, Contracting
1.304.220.6387 or 1.800.624.6961, ext. 6387
Email: dbarrett@healthplan.org

Kim Rogers, MBA, RN – Director, Contracting
1.304.285.6512 or 1.800.624.6961, ext. 6512
Email: krogers@healthplan.org

Tiwatha Murdock—Network Development Manager
1.330.834.2271 or 1.877.236.2289, ext. 2271
Email: tmurdock@healthplan.org

Hallie Hendricks—Contract Specialist
1.330.834.2330 or 1.877.236.2289, ext. 2330
Email: hhendricks@healthplan.org

Provider Credentialing
Responsibilities - Credentialing/recredentialing all providers. Update expired credentials such as DEA, license, liability insurance, certifications. Assist with the addition of new providers to current group contract. Entry of new providers into the system.

Danielle Kaluger—Manager, Credentialing
1.740.699.6129 or 1.800.624.6961, ext. 6129
Email: dkaluger@healthplan.org

Tiffany Gerig—Ancillary Credentialing Representative
1.330.834.2204 or 1.877.236.2289, ext. 2204
Email: tgerig@healthplan.org

Tina Luff—Physician Initial Credentialing Representative
1.740.699.6279 or 1.800.624.6961, ext. 6279
Email: tluff@healthplan.org
**Provider Support Services**

Responsibilities - Entry of new provider information. Update provider changes to current groups. Assist providers with issues which cannot be resolved through THP’s Customer Service Department.

**Cayla Delman, Provider Relations Representative (internal)**
1.740.699.6996 or 1.800.624.6961, ext. 6996  
Email: cdelman@healthplan.org

**Ashley Gummer – Provider Relations Representative (internal)**
1.740.699.6248 or 1.800.624.6961, ext. 6248  
Email: agummer@healthplan.org

**EDI Support Center**

Responsibilities – Set up and maintain EDI and direct deposit information. Assist with provider website questions and access. Troubleshoot and advise on issues between clearinghouse, provider and THP.

**Ashley Gummer – Provider Relations Representative /EDI Support**
1.740.699.6248 or 1.800.624.6961, ext. 6248  
Email: hpecs@healthplan.org
Provider Engagement

Responsibilities - Perform educational and site visits and assist providers with issues which cannot be resolved through THP’s Customer Service Department.

Wheeling Office:

Kayla Shreve – Wheeling Regional Manager Provider Engagement
1.740.699.6102 or 1.800.624.6961, ext. 6102
Email: kshreve@healthplan.org

Natalie Stewart – Provider Engagement Representative
1.330.834.2265 or 1.877.236.2289, ext. 2265
Email: nstewart@healthplan.org

Bethani Zelewicz – Provider Engagement Representative
1.740.699.6959 or 1.800.624.6961, ext. 6959
Email: bzelewicz@healthplan.org

Charleston Office

Barbara Good – Charleston Regional Manager Provider Engagement
1.304.720.4947 or 1.800.624.6961, ext. 4947
Email: bgood@healthplan.org

Garrett Coleman – Provider Engagement Representative
1.304.220.639 or 1.800.624.6961, ext. 6394
Email: gcoleman@healthplan.org

Jenny Pauley – Provider Engagement Representative
1.304.220.6356 or 1.800.624.6961, ext. 6356
Email: jpauley@healthplan.org

Nicole Rendinell – Provider Engagement Representative
1.304.220.6392 or 1.800.624.6961, ext. 6392
Email: nrendinell@healthplan.org

Seth Shockey – Behavioral Health Provider Engagement Representative
1.304.720.4957 or 1.800.624.6961, ext. 4957
Email: sshockey@healthplan.org

Morgantown Office

Rachel Waybright Tignor – Regional Manager Provider Engagement
1.304.285.6510 or 1.800.624.6961, ext. 6510
Email: rltignor@healthplan.org

Marjorie Burdick – Provider Engagement Representative
1.304.285.6507 or 1.800.624.6961, ext. 6507
Email: mburdick@healthplan.org

Jessica Legg – Provider Engagement Representative
1.304.285.6509 or 1.800.624.6961, ext. 6509
Email: jlegg@healthplan.org

Grace Matthews – Provider Engagement Representative
1.304.887.0400
Email: gmatthews@healthplan.org
Provider Quick Reference Guide

Our dedicated and friendly staff at The Health Plan are here to assist you when issues, questions or concerns arise. We’ve compiled a quick reference guide that lists important contacts that are most relevant for our providers.

<table>
<thead>
<tr>
<th>Customer Services – Assistance with Eligibility, Pre-Authorization and Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Customer Service – <strong>Fully Funded</strong> (including Commercial)</td>
</tr>
<tr>
<td>Customer Service – <strong>Self-Funded</strong></td>
</tr>
<tr>
<td>Customer Service - <strong>Medicare</strong></td>
</tr>
<tr>
<td>Customer Service - <strong>Medicaid</strong></td>
</tr>
<tr>
<td>Behavioral Health (24/7)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Paper Claims Submission</th>
<th>The Health Plan 1110 Main Street Wheeling, WV 26003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordination of Benefits (COB)</td>
<td>740.695.7903</td>
</tr>
<tr>
<td>Electronic Data Interchange (EDI) Support</td>
<td>740.699.6248</td>
</tr>
<tr>
<td>eviCore healthcare</td>
<td>1.877.791.4101</td>
</tr>
<tr>
<td>NantHealth</td>
<td>1.888.482.8057</td>
</tr>
<tr>
<td>Palladian Health</td>
<td>1.877.244.8514</td>
</tr>
<tr>
<td>Physician Access Line (24/7)</td>
<td>1.866.687.7347</td>
</tr>
<tr>
<td>Provider Information</td>
<td>Go to healthplan.org, “For Providers”</td>
</tr>
<tr>
<td>Urgent or Emergent Admissions (24/7)</td>
<td>1.800.304.9101</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fax Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health</td>
</tr>
<tr>
<td>Medical Records</td>
</tr>
<tr>
<td>Palladian Health</td>
</tr>
<tr>
<td>Provider Relations</td>
</tr>
<tr>
<td>Submit Clinical Information for Review</td>
</tr>
<tr>
<td>Email Contacts</td>
</tr>
<tr>
<td>--------------------------------</td>
</tr>
<tr>
<td>Behavioral Health</td>
</tr>
<tr>
<td>Contracting</td>
</tr>
<tr>
<td>Credentialing</td>
</tr>
<tr>
<td>EDI</td>
</tr>
<tr>
<td>eviCore healthcare</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

- **Behavioral Health**: Behavioralhealthdocuments@healthplan.org
- **Contracting**: dbarrett@healthplan.org or krogers@healthplan.org
- **Credentialing**: dkalugger@healthplan.org
- **EDI**: Hpecs@healthplan.org
- **eviCore healthcare**: clientservices@evicare.com
- **evicare.com**
- **NaviNet**: navinet.navicare.com
- **Palladian Health**: portal.navicare.com
- **THP Corporate Website**: healthplan.org
- **THP Provider Secure Website**: myplan.healthplan.org
- **Provider Search**: findadoc.healthplan.org/
Section 2

Physician Availability
Physician Availability

In an effort to control the high cost of emergency room (ER) utilization and to reduce the unnecessary denial of ER claims, we would like to offer the following information as a reminder of the physician’s role as governed by his/her physician agreement. Physicians need to provide or arrange for service 24 hours a day, seven days per week. The physician should list one to two participating THP physicians as backups. The physician or designated backup(s) are to be available by phone or answering service. Answering machines should contain an appropriate message.

In cases of emergency (except for life endangering situations), The Health Plan members are instructed to call their primary care physician (PCP). If unable to reach their PCP, they are instructed to call The Health Plan 24-hour emergency number at 1.800.624.6961 for their physician’s backups or for further assistance.

Please review access standards. They are also contained in The Health Plan Practice Guidelines and Standards.

Primary Care Physician Responsibilities:

- Maintain continuity of enrollee’s health care by serving as the primary care provider
- Provide access twenty-four (24) hours a day, seven (7) days a week
- Make referrals for specialty care and other medically necessary covered services, both in-network and out-of-network, consistent with THP’s utilization management policies
- Maintain a current medical record for the enrollee, including documentation of all services provided by the PCP, as well as specialty or referral services
- Adhere to EPSDT Periodicity Schedule for enrollees under age twenty-one (21)
- Follow THP’s established procedures for coordination of in-network and out-of-network services for Medicaid enrollees
Primary Care Physician Guidelines

1. You will be listed on The Health Plan’s provider directory under primary care physicians (PCP). (MEMBERS MUST SELECT A PCP.)

2. If you have a medical subspecialty, you may also be listed under a second category for your specialty.

3. If you wish to change to a different category on the provider lists, you must make a request in writing to Provider Relations at providersupport@healthplan.org or by mail to Attention: Provider Relations, 1110 Main Street, Wheeling, WV 26003.

4. If you wish to be listed as NOT ACCEPTING NEW PATIENTS on the provider lists, you must meet the required minimum and make a written request to Provider Relations.

5. PATIENT ROSTER:
   - The PCP patient roster can be obtained through our provider secure portal that enables your office to generate a member roster at any time. The member information is updated every 24 hours, seven days a week. To access The Health Plan’s provider portal, simply click on myplan.healthplan.org. Be sure to cross-reference the member ID number, date of birth, and name that appears on your roster with the information in your member's chart to ensure that they are the same people. Please refer to the “Roster” folder on the left-hand side of your screen after logging onto the provider secure portal to obtain your member roster.
   - You will only have access to patients who have you listed as their PCP. It is important to review your roster. If you have patients who have been attributed to your practice, you should contact them to request that they become established with your practice. If they were assigned in error report this to Provider Relations and we will have Customer Service contact the member to be reassigned.
   - Once you have obtained your roster, it should be checked for patients who:
     - May be listed but have never been seen, AND
     - Patients who are seen regularly but do not appear on the roster.
   - The roster should also be checked before patient appointments.
   - If you wish for the member to choose you as their PCP, have the member call The Health Plan from your office. Members may change their PCP once per month by calling The Health Plan Customer Service Department at 1.800.624.6961.
   - If you want a patient to be removed from your roster, you must submit a request to Provider Relations stating the reason for the request. You may make such a request in the following situations:
     - Noncompliance concerning the physician's orders
     - When a member has been seeing another PCP on a regular basis
     - When a member has been referred by another PCP on a regular basis
     - When a distinct personality clash exists

You will receive a response from Provider Relations, or the member will receive a letter from The Health Plan requesting that they choose another PCP.
PCPs Encouraged to Screen for Behavioral Health Needs

The primary care setting is potentially one of the key points of access to screening, assessment, early intervention, referral, and treatment of behavioral health needs. The primary care provider is often the first to encounter a patient with a mental health or substance abuse need and is in the unique position to assess the patient, utilize brief screening tools and to treat or refer members as needed.

The Health Plan encourages primary care providers to use appropriate screening tools to assess members for behavioral health needs. Screenings should be provided to people of all ages, even the young and the elderly. Screening tools for mental health and substance use disorders can be found at integration.samhsa.gov/clinical-practice/screening-tools. If you need assistance with referral to a behavioral health specialist contact The Health Plan’s Clinical Services Department at 1.800.624.6961 extension 7644 for assistance.

The Health Plan also encourages the sharing of information between primary care and behavioral health providers. For your convenience, the “Authorization to Disclose Health Information to Primary Care Physician and Continuity of Care” form is available on the website at myplan.healthplan.org. "Forms," “Behavioral Health Forms.”

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Substance use disorder (SUD) is a widespread problem. Many times, the primary care physician (PCP) is the first professional to encounter a patient with alcohol or other substance use disorder issues.

The Health Plan suggests a few points for practitioners/providers to consider when encountering patients who may be experiencing problems with substance use disorders.

What PCPs Can Do:

- Carefully ask about SUDs and screen for problem use.
- Make sure the diagnosis is listed in the patient chart and on your claims.
- Follow-up with the patient. Schedule a follow-up appointment or schedule an appointment with a qualified behavioral health clinician. Make sure that a substance use disorder diagnosis is included on each follow-up visit. Patients may want to minimize their use of a substance, so persistence is required in raising the topic and keeping it at the forefront of a patient’s care.
- Encourage the patient to follow through. Express interest in his/her progress.
- Make a clear statement about needing to cut down if use is problematic. Give advice.
- Consult The Health Plan guidelines for the treatment of patients with substance use disorders which includes various screening tools.

Practitioners/providers need to be mindful that substance use disorders can co-occur with other behavioral health problems such as major depression or anxiety disorder, which can make treating substance use disorders or diagnosing a behavioral health disorder more difficult. In instances like this, a referral to a behavioral health provider is prudent. Practitioners/providers wishing to refer a patient for behavioral health services or to facilitate coordination of services may call Clinical Services at 1.800.624.6961, ext. 7644 for assistance. Additional resources on substance use disorders can be found at nida.nih.gov.
Secondary Care Physician Guidelines

Members may select a secondary care physician (SCP).

1. The following provider specialties can be selected as a secondary care provider (SCP):
   - OB/GYN
   - Endocrinologist
   - Oncologist
   - Nephrologist

   A SCP will be listed on The Health Plan’s provider list with two categories: SCP and specialist.
   - Specialist listed as a primary or secondary care physician may require a referral if the specialist is not listed as the member's PCP or SCP.

2. If the member has you selected as a SCP, they pay the PCP copay in most cases, depending on the plan’s summary plan description (SPD).

3. If you wish to change to a different category on the provider list, you must make a request in writing to Provider Relations at providersupport@healthplan.org or by mail to Attention: Provider Relations, 1110 Main Street, Wheeling, WV 26003.

4. If you wish to be listed as NOT ACCEPTING NEW PATIENTS on the provider list, you must meet the minimum requirements and submit a written request to Provider Relations.

5. PATIENT ROSTER:
   - SCP patient rosters can be obtained through our secure provider portal that enables your office to generate a member roster at any time. The member information is updated every 24 hours. To access The Health Plan’s provider website, visit myplan.healthplan.org. Be sure to cross-reference the member ID number, date of birth, and name that appears on your roster with the information in your member's chart to ensure that they are the same people. Please refer to the “Roster” folder on the left-hand side of your screen after logging onto the provider secure portal for obtaining your member roster.
   - You will only have access to patients who have listed you as their SCP.
   - Once you have obtained your roster, it should be checked for patients who may be listed; but have never been seen, and patients who are seen regularly; but do not appear on the roster.
   - The roster should also be checked before patient appointments.
   - If you wish for the member to choose you as their SCP, you may have the member call The Health Plan from your office. Members may change their SCP once per month by calling The Health Plan Customer Service Department at 1.800.624.6961.
   - If you want a patient to be removed from your roster, you must submit a request to Provider Relations stating the reason for the request. You may make such a request in the following situations:
     1. Noncompliance concerning the physician's orders.
     2. When a distinct personality clash exists.
You will receive a response from Provider Relations, or the member will receive a letter from The Health Plan requesting that they choose another SCP. In that case, you will receive a copy of The Health Plan letter to the member.

SCP may provide referrals **only in cases** where the referral is related to care pertaining to his/her specialty. If you are not listed as the member’s SCP, you are considered a specialist and a referral from the PCP is required.

**Specialist Guidelines**

1. You will be listed in The Health Plan provider directory under SPECIALISTS THAT MAY REQUIRE REFERRALS. Although The Health Plan has eliminated the call-in referral to The Health Plan Medical Department, the PCP is still the coordinator of all medical care for the member, and still needs to coordinate referrals to specialists. Members who are a part of the ASO line of business may still require phone-in referrals to a specialist.

2. If you wish to change to a different category on the provider directory, you must make a request in writing to Provider Relations at providersupport@healthplan.org or by mail to Attention: Provider Relations, 1110 Main Street, Wheeling, WV 26003. Your request will be reviewed in accordance with The Health Plan’s credentialing guidelines to assure you meet qualifications required for a specific category.

3. Except in cases of emergency treatment, specialists shall only treat members upon referral from a PCP or a SCP.

4. Except in cases requiring emergency treatment, specialists must submit a report to the appropriate PCP or SCP concerning the proposed plan of specialty treatment, including possible hospitalization or surgery, as soon as possible after examination of a member.

5. Specialists should contact the PCP to arrange referrals to another physician. **Specialist-to-specialist referrals are not generally permitted.** In emergency situations, a specialist to whom a patient has been referred may refer that patient to another specialist only in cases where the referral is related to care pertaining to his/her specialty, i.e., specialized surgery and/or care requiring tertiary services. The plan recommends, however, that the specialist communicate with the PCP regarding the need for the referral in such instances. This may be done after the fact in instances where the emergency may require immediate action.

6. Specialists will send a copy of the member’s treatment record to the appropriate PCP or SCP.
Physician Care of Self or Family

Based on recommendations from the American Medical Association (AMA), The Health Plan upholds that practitioners should not treat themselves or their immediate family members, or members of their household. Accordingly, The Health Plan benefit plans DO NOT permit payment to a provider for treating their family members.

The following degrees of relationship are included within the definition of immediate relative.

- Husband and wife;
- Natural or adoptive parent, child, and sibling;
- Stepparent, stepchild, stepbrother, and stepsister;
- Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law;
- Grandparent and grandchild; and
- Spouse of grandparent and grandchild.

**EMERGENCIES:** In the case of medical emergencies, a THP practitioner can provide care until a qualified practitioner is available.

**ORDERS** (written or verbal): The Health Plan practitioners shall not write orders or dictate verbal orders for themselves or a member of their immediate family.

**PRESCRIPTIONS:** The Health Plan practitioners shall not write prescriptions for themselves or members of their immediate family.

**PCP ASSIGNMENT:** The Health Plan practitioners shall not be permitted to act as primary care physician for themselves or members of their immediate family.
Section 3

Member Benefits
Member Benefits

The Health Plan member handbook is the primary source of information regarding The Health Plan member benefits. The Health Plan member handbook is available upon request.

Office Copayment

Member handbooks are subject to the copayment of the benefit plan chosen.

Vision Benefits

The Health Plan offers benefit riders for vision benefits administered through Vision Service Plan (VSP) for commercial members and Superior Vision for Medicaid and Medicare members. Providers must be a participating provider with the appropriate vision provider to be eligible to offer covered vision services. You will need to verify vision coverage through the appropriate vision carrier.

Please note: Members are entitled to vision benefits only under this separate vision service program.

Members may require ophthalmologic medical services in conjunction with a medical condition. These medical services must be offered through a contracted ophthalmologist or optometrist with The Health Plan. A referral from the primary care physician (PCP) may be required for the member to obtain medical services from an ophthalmologist or optometrist.

Product Matrix

The product matrix lists all the products offered by The Health Plan. This matrix identifies the basic plan design of each product and includes a sample ID card.
<table>
<thead>
<tr>
<th>Member selects Primary Care Physician (PCP)</th>
<th>Referrals required for Specialty Care</th>
<th>Member has OB/GYN Open Access</th>
<th>Member has Mental Health Open Access</th>
<th>Member has Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>COMMERCIAL</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fully Funded HMO</td>
<td>YES</td>
<td>YES, through OB/GYN secondary physician when selected.</td>
<td>YES. Refer to Directory for appropriate providers.</td>
<td>NO</td>
</tr>
<tr>
<td>Fully Insured POS</td>
<td>YES</td>
<td>YES for all in-network OB/GYN services.</td>
<td>YES. Refer to Directory for appropriate providers.</td>
<td>YES</td>
</tr>
<tr>
<td>Fully Insured PPO</td>
<td>NO</td>
<td>YES for all in-network OB/GYN services.</td>
<td>YES. Refer to Directory for appropriate providers.</td>
<td>YES</td>
</tr>
<tr>
<td>Self-Funded HMO, EPO, PPO, POS</td>
<td></td>
<td>Determined by specific employer benefits.</td>
<td>Determined by specific employer benefits.</td>
<td>Determined by specific employer benefits.</td>
</tr>
<tr>
<td>HMO, EPO, POS: YES</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HMO, EPO, POS: NO</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PPO: NO.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services requiring referral/prescription may differ by plan sponsor. Contact The Health Plan to confirm benefits.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MEDICAID</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MHT/WVHB/SSI</td>
<td>YES</td>
<td></td>
<td>YES for all in-network OB/GYN services.</td>
<td>YES. Refer to Directory for appropriate providers.</td>
</tr>
<tr>
<td><strong>MEDICARE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SecureCare HMO*</td>
<td>YES</td>
<td>YES, through OB/GYN secondary physician when selected.</td>
<td>YES. Refer to Directory for appropriate providers.</td>
<td>NO</td>
</tr>
<tr>
<td>SecureCare SNP</td>
<td>YES</td>
<td>YES, through OB/GYN secondary physician when selected.</td>
<td>YES. Refer to Directory for appropriate providers.</td>
<td>NO</td>
</tr>
<tr>
<td>SecureChoice PPO</td>
<td>NO</td>
<td>YES</td>
<td>YES. Refer to Directory for appropriate providers.</td>
<td>YES</td>
</tr>
<tr>
<td>Medicare Supplement</td>
<td>NO</td>
<td>NO. Member may self-refer to any specialist who accepts Medicare.</td>
<td>YES</td>
<td>YES. Any provider who accepts Medicare.</td>
</tr>
</tbody>
</table>

For verification of eligibility or benefit information specific to a particular member, go to myplan.healthplan.org. If you require assistance with registering for access to this secure website, please call 1.800.624.6961, ext. 6248.

* Includes WVU Medicine – The Health Plan SecureCare (HMO)
Commercial HMO Plans

Commercial health maintenance organization (HMO) plans are plans that are fully insured by a Health Insuring Corporation (HIC). Employer groups contract with The Health Plan to provide a health insurance benefit plan and pay a monthly premium to cover eligible employees. The Health Plan assumes the responsibility for providing the benefit package, administering all aspects of the plan and the risk for paying for all covered services. These plans require a member to choose a primary care physician (PCP), and although The Health Plan has eliminated the need for the PCP to call in a referral for specialty physician services, the member must be referred by their PCP and follow precertification guidelines for procedures, diagnostic testing, outpatient surgical procedures, and inpatient admissions. Members do not have out-of-network benefits unless authorized by the plan.

HMO benefit plans generally have copays for:
- Primary and specialty care physician office visits
- Emergency room services
- Urgent care
- Outpatient mental health
- Physical, occupational, and speech therapy
- Durable medical equipment
- Prescription drugs

Members may have a deductible and co-insurance associated with their benefit plan, as well as cost sharing for laboratory and X-rays, not associated with preventive services, depending on the plan.

Commercial Point-of-Service (POS) Plans

Commercial point-of-service (POS) plans are fully insured by a Health Insuring Corporation (HIC). Employer groups, with a minimum size of two employees, contract with The Health Plan to provide a health insurance benefit plan and pay a monthly premium to cover eligible employees.

POS plans are designed to allow members the freedom to choose between having their health care managed or arranged by their primary care physician (PCP) as an in-plan option or the member has the option to manage and arrange their care as an out-of-plan option. The plan provides the benefit package giving the employer the option to choose from a variety of deductibles and copay plans. These plans require a member to choose a PCP, obtain a referral for specialty physician services, and follow precertification guidelines for procedures, diagnostic testing, outpatient surgical procedures, and inpatient admissions.

Members have out-of-plan option benefits and may choose to access services outside The Health Plan network at an increase in their out-of-pocket expense for deductibles, copays, and co-insurance amounts.

POS benefit plans generally have copays for:
- Primary and specialty care physician office visits
- Emergency room services
- Urgent care
• Outpatient mental health
• Physical, occupational, and speech therapy
• Durable medical equipment
• BioTech drugs

Additionally, members are responsible for deductibles and co-insurance amounts associated with their plan benefit.

Commercial Preferred Provider Organization (PPO) Plans

Commercial preferred provider organization (PPO) plans are fully insured by a Health Insuring Corporation (HIC). Employers contract with The Health Plan to provide a health insurance benefit plan and pre-pay a monthly premium to cover eligible employees. Members who are covered under the PPO plan generally are not required to select a primary care physician (PCP) or obtain a referral for specialty physician services. All prior authorization guidelines for procedures, diagnostic testing, outpatient surgical procedures, and inpatient admission apply. By utilizing The Health Plan in-plan or tertiary network, members receive a higher level of benefits. Members who utilize out-of-network providers or fail to preauthorize a service will have increased out-of-pocket expenses for deductibles, copays, and co-insurance amounts.

PPO benefit plans generally have copays for:
• Primary and specialty care physician office visits
• Emergency room services
• Urgent care
• Outpatient mental health benefits
• Physical, occupational, and speech therapy
• Durable medical equipment
• BioTech drugs

Additionally, members are responsible for deductibles and co-insurance amounts associated with their benefit plan.
Sample Commercial ID Cards

This card is issued to members enrolled in a Commercial HMO or PPO plan. This includes WV State employees who are covered by the Public Employees Insurance Agency (PEIA).
SecureCare HMO Medicare Advantage Plan

The Health Plan has entered into a contract with the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers the Medicare program. Under this contract, CMS makes a monthly payment to The Health Plan for each Medicare beneficiary who enrolls in our Plan. This contract requires The Health Plan to provide comprehensive health services to persons who are entitled to Medicare benefits and who choose to enroll in The Health Plan. The Health Plan receives a set rate for each member plus any enrollee premium.

Medicare Advantage benefit plans generally have copays for:

- Primary and specialty care physician office visits
- Inpatient admissions
- Skilled nursing home services
- Emergency room services
- Urgent care
- Outpatient mental health visits
- Physical, occupational, and speech therapy
- Biological drugs
- Durable medical equipment

Members may have a deductible and co-insurance associated with their benefit plan, as well as cost sharing for laboratory and X-rays, not associated with preventive services.

SecureChoice PPO Medicare Advantage Plan

SecureChoice PPO is The Health Plan’s Medicare Advantage preferred provider organization (PPO) option. SecureChoice PPO members are not required to select a primary care physician (PCP) and referrals to specialists are not required. The Health Plan prior authorization requirements apply.

The SecureChoice PPO plan provides benefits at an “in-network” level from The Health Plan’s extensive network of participating providers.

The SecureChoice PPO plan also provides benefits to SecureChoice PPO members at an “out-of-network” level from any Medicare provider of choice at an additional out-of-pocket expense to the member.

The benefits for SecureChoice PPO members are identical to traditional Medicare benefits in addition to enhanced benefits that are offered by The Health Plan.

PPO benefit plans generally have copays for:

- Primary and specialty care physician office visits
- Emergency room services
- Urgent care
- Outpatient mental health benefits
- Physical, occupational, and speech therapy
- Durable medical equipment
- BioTech drugs

Additionally, members are responsible for deductibles and co-insurance amounts associated with their benefit plan.
D-SNP Program (Medicare Advantage Special Needs Plan)

Effective January 1, 2014, The Health Plan began a Medicare Special Needs Plan (SNP) for those members who have a chronic condition. The special needs population are those recipients who qualify for both Medicare and Medicaid. These “dual-eligibles” are individuals who are entitled to Medicare and are also eligible for some level of assistance from their state Medicaid program.

SNP members will select a primary care physician (PCP) and a THP case manager will be assigned to the member.

Provider Reimbursement and Billing

The provider will bill The Health Plan for medically appropriate covered services provided to the D-SNP member. The Health Plan will reimburse the provider for services rendered according to the member’s benefit plan, less any copays, co-insurance, or deductible amounts. The provider will then be eligible to submit any balance associated with the copays, co-insurance, and deductible directly to West Virginia or Ohio Medicaid program.

To obtain referrals or eligibility information please call our Customer Service Department at 1.877.847.7907.

Federal law prohibits Medicare providers from collecting Medicare Part A and Medicare Part B deductibles, co-insurance, or copayments from those enrolled in the dual-eligible program. This program exempts individuals from Medicare cost-sharing liability. Medicare providers must accept the Medicare payment and Medicaid payment (if any) as payment in full for services rendered to an eligible member. Providers who bill a qualified dual-eligible member for amounts above the Medicare and Medicaid payments (even when Medicaid pays nothing) are subject to sanctions. See Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the Balanced Budget Act of 1997. This section of the Act is available at ssa.gov/OP_Home/ssaact/title19/1902.htm.

Providers may not discriminate by refusing to serve enrollees because they receive assistance with Medicare cost-sharing from a state Medicaid program.

If a provider is referred to us who is balance billing or refusing to take D-SNP patients, Medicare MLN Matters documents will be sent to the provider and document the training. This policy is included in Section 4 of the Provider Procedural Manual and published periodically in our quarterly ProviderFocus newsletter.
Sample Medicare ID Cards

This card is issued to Medicare members who are enrolled in our HMO, PPO, or SNP plans. The specific plan will be indicated on the front of their ID card (as shown in the red box below).
Mountain Health Trust and West Virginia Health Bridge (WV Medicaid Program)

Mountain Health Trust (MHT) and WV Health Bridge (WVHB) are fully insured managed care plans offered to Medicaid-eligible residents of West Virginia. The plan requires a member to select a primary care physician (PCP), obtain a referral for specialty physician services, and follow prior authorization guidelines for procedures, diagnostic testing, outpatient surgical procedures, and inpatient admissions. Members do not have out-of-network benefits unless prior authorization is given by the plan.

Under the Medicaid programs, the state of West Virginia determines eligibility and enrollment through a broker hired by the state of West Virginia for enrollment services. Once the member selects The Health Plan, we are notified electronically of enrollment. At that time, a packet of information is sent to the member, along with an ID card from The Health Plan. The MHT and WVHB member will have two cards. The Health Plan ID card, as well as the West Virginia Medicaid card, issued annually, showing eligibility. The Health Plan will not reissue their ID card each month with the exception of a replacement ID card for a lost or misplaced ID card or a change in PCP.

The date appearing on The Health Plan ID card is the actual date the card printed and not the effective date of coverage. The effective date of coverage is always the first of the month, except for a newborn.

You may contact The Health Plan Customer Service Department at 1.888.613.8385 to check eligibility or if you have any question regarding MHT and WVHB programs. Eligibility, benefits, and claims status are available through our secure provider portal.

Sample Medicaid ID Cards

This card is issued to Medicaid members who are enrolled in our Mountain Health Trust (MHT) or WV Health Bridge plans (WVHB). The specific plan and group number that a member is enrolled in will be indicated on the front of their ID card (as seen in the red boxes below).

Take note of the member’s group number:
• Mountain Health Trust plan (MHT): 0140, or 0142 for SSI members
• WV Health Bridge plan (WVHB): 0141
Administrative Services Only (ASO) Self-Funded Employer Groups

Many employers choose to pay claims as they are incurred, rather than pay a prepaid monthly premium for their employee’s medical benefits. The Health Plan offers administrative services only (ASO) plans to assist these employers with administering their benefit plan. The plan offers them a contracted network of providers, utilization management services, medical management, prescription plans, customer service and claims processing. These plans are most often designed by the employer group and administered by The Health Plan. ASO plan benefits, copays, deductibles, and ID cards may vary from the standard insured plans offered by The Health Plan.

Sample Self-Funded ID Cards

This card is issued to members who are enrolled in a Self-Funded plan. The company name will differ on these cards (as shown in the red box below).

Note: Services requiring referral/ prior authorization may differ by plan. Contact The Health Plan to confirm benefits.

![Sample Self-Funded ID Card Front](image1)

![Sample Self-Funded ID Card Back](image2)
Vision Service Benefit

Members enrolled through The Health Plan Commercial and Medicare programs may also have vision benefits. Benefits are administered through Vision Service Plan (VSP) for Commercial members. Superior Vision administers vision benefits for THP Medicare members. Please refer to resources available through VSP and Superior Vision for information on benefits and coverage under these vision plans.

Vision Service Plan (vsp.com)
Monday - Friday 8 AM to 11 PM
Saturday 10 AM to 11 PM
Sunday 10 AM to 10 PM
Closed Thanksgiving Day and Christmas Day
1.800.877.7195
For assistance with translation, hearing impaired callers may call 1.800.428.4833.

Superior Vision (superiorvision.com)
Monday – Friday 8 AM – 9 PM EST
1.844.353.2900

Members enrolled through The Health Plan WV Medicaid programs may have vision benefits. Those benefits are administered through Superior Vision. Refer to Section 5 for additional information on Medicaid vision benefits.

Billing for Medical Eye Exams with a Vision Screening

In most situations, a vision screening (CPT 92015 Determination of Refractive State) is considered non-covered under a medical benefit plan but is often covered by a vision benefit plan. When there is the need to provide a vision screening as part of a medical exam, the following billing guidelines will assist you in obtaining appropriate reimbursement for the vision screening if there is a benefit that is available through The Health Plan’s vision benefit vendors, provided you are a participating provider.

Billing Procedures

The visit is billed to The Health Plan on the appropriate CMS 1500 form with the following codes:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>92002, 92004, 92012, or 92014</td>
<td>Eye exam, new or established patient</td>
</tr>
<tr>
<td>92015</td>
<td>vs Determination of refractive state</td>
</tr>
</tbody>
</table>

After The Health Plan has made payment for the exam and denied the refraction as non-covered, you can then submit the visit code and the 92015 – Determination of Refractive State – to The Health Plan’s vision provider (as long as you are a contracted provider) for payment of the refraction.

You must include our payment voucher (with the page that shows the explanation of the denial codes) when submitting to VSP for the remaining portion.
Vision provider will coordinate benefits with The Health Plan and pay only the refraction which is still due when a benefit is available to cover the refraction. If the member has a vision benefit through some other plan that is not associated with The Health Plan, you may also submit a claim for the refraction to that plan in the same manner and they will adjudicate the claim according to their plan guidelines.

The Health Plan encourages our diabetic members to see an in-plan ophthalmologist or optometrist for an annual dilated retinal exam (excludes self-funded ASO participants.) If a 92015-Determination of Refractive State is also done during the visit, the following billing procedures apply.

- **Without a referral** and with a waiver of the associated office copayment.

Once The Health Plan has made payment, you can then submit the visit code and the 92015-Determination of Refractive State to the appropriate vision plan, for payment of the refraction. You **must** include our payment voucher when submitting to VSP for the remaining portion. VSP will coordinate benefits with The Health Plan and pay only the refraction which is still due.

---

**Provider Reimbursement Voucher**

<table>
<thead>
<tr>
<th>CLAIM NO</th>
<th>DATE SVR</th>
<th>CPT</th>
<th>MODIFIERS</th>
<th>UNT</th>
<th>BILLED</th>
<th>ALLOWED</th>
<th>DISALLOW</th>
<th>MEMBER RESPONSIBLE</th>
<th>DEDUCT</th>
<th>OTHER</th>
<th>ADMIN</th>
<th>PAID</th>
<th>ADJ</th>
<th>WH</th>
<th>FEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>20112011</td>
<td>11/04/2011</td>
<td>9204</td>
<td>00</td>
<td>SUNSHINE, SALLY A</td>
<td>165.00</td>
<td>147.69</td>
<td>17.31</td>
<td>15.00</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>32.00</td>
<td>.00</td>
<td>.00</td>
<td>L NV</td>
</tr>
<tr>
<td>20112011</td>
<td>11/04/2011</td>
<td>92015</td>
<td>00</td>
<td>JANE A. DOE</td>
<td>32.00</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>32.00</td>
<td>.00</td>
<td>.00</td>
<td>132.69</td>
<td>.00</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>1</td>
<td>197.02</td>
<td>179.69</td>
<td>17.33</td>
<td>15.00</td>
<td>.00</td>
<td>.00</td>
<td>32.00</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td></td>
</tr>
</tbody>
</table>

**Include the page of the voucher that has explanation of the denial codes when submitting to VSP or Superior Vision.**

---

**Provider Reimbursement Voucher**

<table>
<thead>
<tr>
<th>ADJUSTMENT CODE DESCRIPTION</th>
<th>#</th>
<th>CLAIM HAS CLEARED PROCESSING EDITS</th>
<th>D109</th>
<th>Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>204</td>
<td>This service/equipment/drug is not covered under the patients current benefit plan.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>97</td>
<td>Payment is included in the allowance for another service/procedure.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Co-payment Amount</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>45</td>
<td>Charges exceed your contracted/legislated fee arrangement.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>N418</td>
<td>Misprinted claim. See the payer's claim submission instructions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>N538</td>
<td>A facility is responsible for payment to outside providers who furnish these services/supplies/drugs to its patients/residents.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The Health Plan’s Members’ Rights and Responsibilities Statement

Statement of Members’ Rights

• Members have the right to receive information regarding the plan. Information such as a summary of the plan’s accreditation report and the plan’s services, policies, benefits, limitations, practitioners and providers. Members have the right to information on member’s rights and responsibilities and any charges they may be responsible for. Members have the right to obtain evidence of medical credentials of a plan provider, (i.e. diplomas and board certifications). If a member needs assistance with any of the above, they may contact The Health Plan’s Customer Service Department at 1.888.847.7902.

• Members can expect to receive courteous and personal attention and to be treated with dignity. Plan employees, providers and their staff will respect members’ privacy.

• All information concerning The Health Plan member’s medical history and enrollment file is confidential. The member has a right to approve or refuse the release of personal information by The Health Plan except when the release is required by law. The Health Plan assures that all patient information is held in the strictest confidence. All staff must adhere to The Health Plan confidentiality policy revised and adopted in November 1993. This statement acknowledges the confidential nature of the review work, includes an agreement to honor that confidentiality, and documents the consequences of failing to do so.

• The member’s personal choice of a primary care physician (PCP) enables the member to participate in the management of his/her total health care needs, including the right to refuse care from a specific practitioner. Members of The Health Plan are encouraged to establish a relationship with their chosen PCP so that they can work together to maintain good health. Members of The Health Plan may change physicians once per calendar month if so desired (depending upon the availability of the chosen physician).

• The Health Plan members have the right to express their comments, opinions or complaints about The Health Plan or the care provided and to file a grievance for an administrative or medical complaint and hearing procedures without reprisal from The Health Plan. Members also have the right to have coverage denials reviewed by the appropriate medical professionals consistent with The Health Plan review procedures. Both informal and formal steps are available to members to resolve all complaints/grievances.

• The Health Plan members may participate in decision-making about their health care when possible and within the plan guidelines. Members have a right to discuss with providers, without limitations or restrictions being placed upon the providers, appropriate or medically necessary treatment options for their condition(s) regardless of cost or benefit coverage. However, this does not expand coverage by the plan. Members also have the right to formulate advance directives.

• The Health Plan members have the right to have a meaningful voice in the organization by expressing their suggestions and comments regarding their health plan coverage, policies, members’ rights and responsibilities, and operations. Member’s comments and opinions are received by The Health Plan through yearly member satisfaction surveys, telephone calls from our members, by email to: information@healthplan.org or through our corporate website. Member’s comments/opinions are also received through various The Health Plan departments.
• Members have the right to full disclosure, from their health care provider, of any information relating to their medical condition or treatment plan. Members have the right to examine and offer corrections to their own medical records, in accordance with applicable federal and state laws. The plan will not release personal health information to an employer, or its designee, without a signed plan authorization form by the member. For information on obtaining medical records, contact The Health Plan Customer Service Department at 1.888.847.7902.

Statement of Members’ Responsibilities

• A member must choose a PCP for each person listed on The Health Plan ID card. The member has a responsibility to maintain a relationship with a PCP, as the PCP will act as the coordinator for all his/her health care needs.

• A member must identify him/herself as a member of The Health Plan to avoid unnecessary errors; always carry their ID cards; and never permit anyone else to use their ID card.

• A member is asked, through outreach calls to new members, to read their member handbook and understand the benefits and procedures for receiving health care services. To assure maximum coverage, the member has a responsibility to follow the rules and to contact The Health Plan for assistance, if necessary.

• A member is required to notify The Health Plan of any changes in the following:
  1. Name, address, telephone number
  2. Number of dependents (marriage, divorce, newborns, etc.)
  3. Loss of an identification card
  4. Selection of a primary care physician

• Members are asked to be on time for appointments and to call the physician’s office promptly if an appointment can’t be kept.

• Members must provide necessary information to the providers rendering care. Such information is necessary for the proper diagnosis and/or treatment of potential or existing conditions.

• Understand your health problems and participate in developing mutually agreed upon treatment goals, to the degree possible, and follow those instructions and guidelines given by those providers who deliver health care services.

• If members receive emergency care outside The Health Plan’s service area, they are required to contact The Health Plan as soon as possible within 48 hours.

• Members must contact their PCP, secondary care physician or OB/GYN before seeking any specialty physician/service.

• Members must provide The Health Plan with all relevant, correct information and pay The Health Plan any money owed according to coordination of benefits or subrogation policies.

• Members must make required copayments under the schedule of benefits.

• Members are asked to be courteous and respectful of The Health Plan employees, providers, and their staff.
Discrimination is Against the Law

The Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, as such:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, as such:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact The Health Plan Customer Service Department.

If you believe that The Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: The Health Plan Appeals Coordinator, 1110 Main Street, Wheeling, WV 26003, Phone: 1-877-847-7907, TTY: 711, Fax 740.699.6163, Email: info@healthplan.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance The Health Plan Customer Service Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1.800.368.1019, 1.800.537.7697 (TDD)


ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-877-847-7907 (TTY: 711).


注意：如果您使用繁体中文，您可以免费获得语言援助服务。请致电 1-877-847-7907（TTY：711）


Revised 5/2020
Section 4

Medicare
SecureCare HMO Medicare Advantage Plan

The Health Plan has entered into a contract with the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers the Medicare program. Under this contract, CMS makes a monthly payment to The Health Plan for each Medicare beneficiary who enrolls in our plan. This contract requires The Health Plan to provide comprehensive health services to persons who are entitled to Medicare benefits and who choose to enroll in The Health Plan. The Health Plan receives a set rate for each member plus any enrollee premium.

Medicare Advantage benefit plans generally have copays for:

- Primary and specialty care physician office visits
- Inpatient admissions
- Skilled nursing home services
- Emergency room services
- Urgent care
- Outpatient mental health visits
- Physical, occupational, and speech therapy
- Biological drugs
- Durable medical equipment

In keeping with our mission, we have identified members’ rights, along with their responsibilities, that are clearly indicated in the member’s handbook.

The benefits for SecureCare HMO members are identical to traditional Medicare benefits, in addition to enhanced benefits that are offered by The Health Plan.

It is imperative that you are aware of these rights and responsibilities as a participating provider with The Health Plan. You are expected to assist our members by making them aware of their rights and by supporting these within your practice. Please refer to this section of the manual for important information regarding CMS quality standards you are required to meet when caring for Medicare Advantage enrollees. The following Member Services Department is available to assist with any member issues that may arise at 1.877.847.7907.
SecureChoice PPO Medicare Advantage Plan

SecureChoice PPO is The Health Plan’s Medicare Advantage preferred provider organization (PPO) option. SecureChoice PPO members are not required to select a primary care physician (PCP) and referrals to specialists are not required. The Health Plan preauthorization requirements apply.

The SecureChoice PPO plan provides benefits at an “in-network” level from The Health Plan’s extensive network of participating providers.

The SecureChoice PPO plan also provides benefits to SecureChoice PPO members at an “out-of-network” level from any Medicare provider of choice at an additional out-of-pocket expense to the member.

The benefits for SecureChoice PPO members are identical to traditional Medicare benefits, in addition to enhanced benefits that are offered by The Health Plan.

It is imperative that you are aware of these rights and responsibilities as a participating provider with The Health Plan. You are expected to assist our members by making them aware of their rights and by supporting these within your practice. Please refer to this section of the manual for important information regarding CMS quality standards you are required to meet when caring for Medicare Advantage enrollees. The following Member Services Department is available to assist with any member issues that may arise at 1.877.847.7907.
D-SNP Medicare Advantage Special Needs Plan

Effective January 1, 2014, The Health Plan began a Medicare Special Needs Plan (SNP) for those members who have a chronic condition. The special needs population are those recipients who qualify for both Medicare and Medicaid. These “dual-eligibles” are individuals who are entitled to Medicare and are also eligible for some level of assistance from their state Medicaid program.

The Health Plan received approval as a contracted MA-PD (Medicare Advantage Prescription Drug) plan that offers a SNP program by completing a Model of Care (MOC) for Centers for Medicare and Medicaid Services (CMS). This approval applies to the Dual-Eligible Special Needs Plan (D-SNP).

The Health Plan has developed the MOC to provide comprehensive care management to members enrolled in the D-SNP. The Health Plan’s MOC is a written document describing measurable goals of the program. The Health Plan staff structure, care management roles and interdisciplinary care team (ICT) use clinical practice guidelines and protocols to provide yearly training for personnel and our providers. The care management team uses a health risk assessment tool to collect information about our members to develop an individualized plan of care.

**Measurable goals**

- Improve access to essential services including medical, behavioral health, and social services by providing a comprehensive network. Every SNP member will be assigned a case manager with licensed social workers readily available.
- SNP members will select a primary care physician (PCP) and a THP case manager will be assigned to the member.
- Streamline the process of transition of care across health care settings, providers, and health services coordinated by the physician/provider and the care manager.
- Improve access to preventive care.
- Improve member health outcomes through participating in annual Healthcare Effectiveness Data and Information Set (HEDIS®) data collection, as well as member surveys.

The above list is just a brief description of some of our measurable goals.

**Provider reimbursement and billing**

The provider will bill The Health Plan for medically appropriate covered services provided to the D-SNP member. The Health Plan will reimburse the provider for services rendered according to the member’s benefit plan, less any copays, coinsurance, or deductible amounts. The provider will then be eligible to submit any balance associated with the copays, coinsurance, and deductible directly to the West Virginia or Ohio Medicaid program.

**Provider education**

Provider education will be conducted by several approaches: face-to-face, web-based training, seminars and ProviderFocus newsletter articles.

To access our MOC and the D-SNP MOC Annual Training presentations are on the secure provider portal under “Resource Library,” “Training and Education.”

To obtain referrals or eligibility information please call our Customer Service Department at 1.877.847.7907.
Federal law prohibits Medicare providers from collecting Medicare Part A and Medicare Part B deductibles, co-insurance, or copayments from those enrolled in the dual-eligible program. This program exempts individuals from Medicare cost-sharing liability. Medicare providers must accept the Medicare payment and Medicaid payment (if any) as payment in full for services rendered to an eligible member. Providers who bill a qualified dual-eligible member for amounts above the Medicare and Medicaid payments (even when Medicaid pays nothing) are subject to sanctions. See Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the Balanced Budget Act of 1997. This section of the Act is available at ssa.gov/OP_Home/ssact/title19/1902.htm

Providers may not discriminate by refusing to serve enrollees because they receive assistance with Medicare cost-sharing from a state Medicaid program.

If a provider is referred to us who is balance billing or refusing to take D-SNP patients, Medicare MLN Matters documents will be sent to the provider and document the training. This policy is included in this section of the Provider Procedural Manual and also published periodically in our quarterly ProviderFocus newsletter.
Coordination of Benefits
Medicare Advantage Secondary Payer

Medicare Advantage is not always the primary payer for health insurance claims. The Health Plan will comply with the Centers for Medicare and Medicaid Services’ (CMS) requirement to provide information pertaining to claims in which Medicare Advantage is secondary. Medicare Advantage is the secondary payer when the beneficiary is entitled to veteran’s benefits, workers’ compensation, black lung benefits, or employer group coverage based on the Medicare secondary payer guidelines.

THP Insurance Company Medicare Supplemental Plans

Medicare beneficiaries who have Medicare as their primary insurance pay a monthly premium to The Health Plan to cover their Medicare deductibles and coinsurance. The Plan provides benefit packages that are designed by Medicare and administer all aspects of the plan in accordance with Medicare guidelines. These plans DO NOT require a member to choose a primary care physician (PCP) or obtain a referral for specialty physician services.

Medicare Noncovered Service Guidelines

The Health Plan Medicare Advantage plans, SecureCare (HMO), SecureChoice (PPO), or SecureCare SNP (HMO SNP), fall under Medicare Advantage (Part C) rules. These rules require The Health Plan to provide appropriate notice of non-coverage/coverage to the members and educate providers on 1) coverage and exclusions of medical services; 2) limits of plan coverage; and 3) how to correctly advise members prior to providing services of such limitations or service exclusion under Medicare. To ensure that you understand what your role and responsibility is concerning covered and non-covered medical services we are providing this provider manual as a guide.

Providing Notice of Non-Coverage

The first method The Health Plan utilizes to educate members of non-covered services is provided upon enrollment through the Evidence of Coverage (EOC) booklet Chapter 4, Section 3: “What services are not covered by the plan?” The second method is provided through the “Notice of Denial (or partial denial) of Medical Coverage” issued through the pre-service determination (also known as “prior authorization”, coverage determination or organization determination) process. Lastly, for every service that is billed to The Health Plan for payment, the member receives Explanation of Benefits (EOB) that provides an explanation of the charges and what, if any, the member is financially responsible for paying to the provider.

Unsure if Covered

For a service or item that is typically not covered, but could be covered under specific conditions (e.g., dental care that is necessary to treat an illness or injury), the EOC, in and of itself, is not adequate notice of non-coverage for purposes of determining member financial liability. In such instances, the appropriate process is for the member, or the provider acting on behalf of the member, to request a pre-service determination.
Never Covered
However, if a service is never covered by the plan (statutorily excluded from coverage per Medicare rules) and the plan’s Evidence of Coverage (EOC) provided to the member is clear that the service or item is never covered, The Health Plan is not required to hold the member harmless from the full cost of the service or item.

Appeal Rights
For any payment or coverage request for service that The Health Plan receives that is denied, a standardized denial notice, as stated above, is provided with appeal rights. The member, or you as their treating provider, has the right to appeal any denial of a service or item.

Member Liability
When the provider, or the plan acting on behalf of the provider, can show that a member was notified (via a clear exclusion in the EOC or the standardized denial notice) prior to receipt of the item or service that:

a) The item or service is not covered by the plan; or

b) That coverage is available only if the member is referred for the service by a contracted provider

And nonetheless, the member receives that item or service in the absence of a referral, the regulation at §422.105(a) does not require that plans hold the member harmless from the full cost of the service or item charged by the provider.

Medicare Advantage Billing Rules are Different
This page explains how and when to bill a member for non-covered services.

As a contracted provider with The Health Plan you must always submit a claim for payment of services to The Health Plan prior to billing our members, even if you have received a pre-service determination denial.

Billing for Non-covered Services
GY - No pre-service determination was made
Use this modifier to tell us that you informed/explained to the member that in his/her Health Plan EOC there was a “clear” exclusion and the service was not covered.

GA - Pre-service notice of non-coverage was provided by the plan
Use this modifier to tell us that:

- A pre-service determination was requested and the “Notice of Denial (or partial denial) of Medical Coverage” was issued; or

- The member either refused your offer of obtaining a pre-service determination or wanted to proceed with the service.

Note: When using this modifier please also provide the pre-service determination number in field #23 of the CMS1500 form.

When claims are billed with these modifiers, they are processed with the appropriate codes for member financial liability and you may bill the member.
However, if you bill us for **non-covered** services **without** using the GA or GY modifier, The Health Plan will deny your claim as provider responsibility. If you bill us for **covered** services **with** the GY or GA modifier, The Health Plan will deny your claim for incorrect use of modifier.

Part of your responsibility as a contracted provider is to inform your patients when a service is not covered (or statutorily excluded) by The Health Plan. In order for The Health Plan Medicare department to know if you have given proper notice of non-coverage to our members, you must follow the billing rules and use the modifiers as stated above. Following the billing rules and appropriate use of the modifiers ensures that you understand when to provide proper notice of non-coverage of medical services to our Medicare Advantage plan members in advance and limits the confusion of coverage and financial responsibility between the members and The Health Plan.

**IMPORTANT REMINDER: Improper Use of Advance Notices of Non-Coverage (ABN)**

On May 5, 2014 CMS released a memo titled “Improper Use of Advance Notices of Non-coverage”, directing all Medicare Advantage organizations (MAO) and their contracted providers to cease with using ABN notices and ABN-like notices as they are not compliant with the Medicare Advantage organization determination requirements. Per CMS, an ABN does not apply in or under the Medicare Advantage context because a MAO member has the right under these statutes and regulations to a pre-service determination prior to receiving services.

For information on this topic, see the Claims Processing Manual Chapter 1 and MLN Booklet: [Medicare Advance Written Notices of Noncoverage ICN 006266](https://www.cms.gov/MLNProducts/MLNBooklets/ICN006266.pdf)

---

**CMS Quality Measures/Standards**

Quality healthcare is a high priority for the President, the Department of Health and Human Services (HHS), and the Centers for Medicare & Medicaid Services (CMS). CMS implements quality initiatives to assure quality health care for Medicare beneficiaries through accountability and public disclosure. CMS uses quality measures in its various quality initiatives that include quality improvement, pay for reporting, and public reporting.

**What are Quality Measures?**

Quality measures are tools that help us measure or quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care. These goals include effective, safe, efficient, patient-centered, equitable, and timely care.

Download the following Medicare Learning Network Booklets:

- [CMS Initial Preventive Physical Examination](https://www.medicare.gov/medicare-beneficiaries/preventive-care/initiation-preventive-physical-exam.html)
- [CMS Annual Wellness Visit](https://www.medicare.gov/medicare-beneficiaries/preventive-care/annual-wellness-visit.html)
- [CMS Preventive Services](https://www.medicare.gov/medicare-beneficiaries/preventive-care/preventive-services.html)
Appointment of Representative Statement for a Medicare Member

To appoint a representative, a Medicare member or their representative should complete the form entitled: Appointment of Representative -CMS-1696 - PDF.

If you do not use form CMS-1696, your appointment must:

- Be in writing and signed and dated by you and your representative;
- Provide a statement appointing the representative to act on your behalf;
- Authorize the release of your personal health information to your representative;
- Include a written explanation of the purpose and scope of the representation;
- List your name and your representative’s names, phone numbers, and addresses;
- Include your Medicare Number (Health Insurance Claim Number or Medicare Beneficiary Identifier) or National Provider Identifier (NPI);
- Indicate your representative’s professional status, if any, or relationship to you; and
- Be filed with the entity processing your appeal.

Unless revoked, an appointment is considered valid for one year from the date the form is signed. Once the form is filed, it is valid for the duration of the appeal. Therefore, a signed form can be used for more than one appeal as long as the appeal is filed within one year of the date on the form.

In addition, there are certain individuals who can bring an appeal on the member’s behalf, pursuant to State or other applicable laws. Such an individual, known as an "authorized representative," may be a court-appointed guardian, an individual who has durable power of attorney, a health care proxy, or a person designated under a State's health care consent statute.

Appointment of Representative Forms are available English, Spanish & Large Print.
Notice of Medicare Noncoverage (NOMNC)

When to Deliver the NOMNC

A Medicare provider, or The Health Plan, must deliver a completed copy of the Notice of Medicare Non-Coverage (NOMNC) to beneficiaries/enrollees receiving covered skilled nursing, home health (including psychiatric home health), comprehensive outpatient rehabilitation facility, and hospice services.

The NOMNC must be delivered at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily.

Provider Delivery of the NOMNC

Providers must deliver the NOMNC to all beneficiaries eligible for the expedited determination process per Chapter 4, Section 260 of the Medicare Claims Processing Manual and Chapter 13, Sections 90.2-90.9 of the Medicare Managed Care Manual. A NOMNC must be delivered even if the beneficiary agrees with the termination of services. Medicare providers are responsible for the delivery of the NOMNC. Providers may formally delegate the delivery of the notices to a designated agent such as a courier service; however, all of the requirements of valid notice delivery apply to designated agents.

The provider must ensure that the beneficiary or representative signs and dates the NOMNC to demonstrate that the beneficiary or representative received the notice and understands that the termination decision can be disputed. Use of assistive devices may be used to obtain a signature.

Instructions and CMS Form 10055 are available on the CMS website.
Medicare Outpatient Observation Notice (MOON)

On August 6, 2015, Congress passed the Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act, which requires all hospitals and critical access hospitals (CAHs) to provide written and oral notification to all Medicare beneficiaries receiving observation services as outpatients for more than twenty-four (24) hours. The written notice must include the reason the individual is receiving observation services and must explain the implications of receiving outpatient observation services, in particular the implications for cost-sharing requirements and subsequent coverage eligibility for services furnished by a skilled nursing facility.

The Medicare Outpatient Observation Notice (MOON) was developed by the Centers for Medicare & Medicaid Services (CMS) to serve as the standardized written notice. Effective March 8, 2017, the MOON must be presented to Medicare beneficiaries, including those with Medicare Advantage plans, to inform them that the observation services they are receiving are outpatient services and that they are not an inpatient of the hospital or CAH. Hospitals and CAHs must deliver the notice no later than thirty-six (36) hours after observation services are initiated or sooner if the individual is transferred, discharged, or admitted.

The hospital or CAH must obtain the signature of the patient or a person acting on behalf of the patient (“representative”) to acknowledge receipt of the notification. If the individual or representative refuses to sign it, the written notification is signed by the hospital staff member who presented it.

The CMS approved standardized MOON form (CMS-10611) and accompanying instructions are available on the CMS website.

The Health Plan will monitor hospitals and critical care hospitals for compliance to valid delivery of the MOON on a yearly basis.
Medicare Appeals Overview

When an enrollee requests coverage for a particular service, the decision on whether to provide such coverage is considered an “Organization Determination.” Enrollees have the right within 60 days of a denial to request either a standard pre-service (30-day) or post service claim (60-day) or expedited (72 hours) reconsideration whenever a Medicare Advantage organization has denied an enrollee’s request for services, Part B drugs will have a standard turn-around time of 7 days effective January 1, 2020.

Where the Medicare Advantage organization affirms its advice “Organization Determination” in whole or in part, the Medicare Advantage organization must automatically forward the case file to CMS’s independent review entity so that it may make a final reconsidered determination. CMS contracts with MAXIMUS Federal Service, Inc.

The parties to an organization determination for purposes of an appeal include:

- The enrollee (including his or her representative);
- An assignee of the enrollee (i.e., a physician or other provider who has furnished a service to the enrollee and formally agrees to waive any right to payment from the enrollee for that service);
- The legal representative of a deceased enrollee’s estate; or
- Any other provider or entity (other than the Medicare health plan) determined to have an appealable interest in the proceeding.

Who may request reconsideration (Chapter 13 Medicare Managed Care Manual – 70.1)

An enrollee, an enrollee’s representative or a non-contract physician or provider to the Medicare health plan may request that the determination be reconsidered. However, contract providers do not have appeal rights. An enrollee, an enrollee’s representative, or physician (regardless of whether the physician is affiliated with the Medicare health plan) are the only parties who may request that a Medicare health plan expedite a reconsideration.

For standard pre-service reconsiderations, a physician who is providing treatment to an enrollee may, upon providing notice to the enrollee, request a standard reconsideration on the enrollee’s behalf without submitting a representative form.

If the reconsideration request comes from the enrollee’s primary care physician in The Health Plan’s contract network, no enrollee notice verification is required.

If the request comes from either an in-network (contract) physician or a non-contract physician, and the patient’s record indicates he or she visited this physician at least once before, a Medicare health plan may assume the physician has informed the enrollee about the request and no further verification is needed.
If this appears to be the first contact between the physician requesting the reconsideration and the enrollee, a Medicare health plan is to undertake reasonable efforts to confirm the physician has given the enrollee appropriate notice. For example:

- If the physician makes the request by phone, during the call a health plan may confirm the physician gave the enrollee notice that he or she is acting on the enrollee’s behalf.
- The physician makes the request by a fax, letter, or email, and the enrollee is copied on the correspondence, and/or the writing includes a statement affirming that the enrollee knows that the physician is acting on the enrollee’s behalf with the enrollee’s knowledge and approval.
- The Medicare health plan may call the enrollee and ask if he or she knows that this physician making the request is acting on his or her behalf with his or her knowledge and approval.

Notice of Medicare Hospital Discharge Appeals Notices

An Important Message from Medicare about Your Rights (Form CMS-R-193)

Hospitals are required to deliver the Important Message from Medicare (IM), CMS-R-193, to all Medicare beneficiaries (Original Medicare beneficiaries and Medicare Advantage plan enrollees) who are hospital inpatients. The IM informs hospitalized inpatient beneficiaries of their hospital discharge appeal rights. A detailed notice of discharge (DND) is given only if a beneficiary requests an appeal. The DND explains the specific reasons for the discharge.

Forms and instruction can be found on the CMS website.

Detailed Notice of Discharge (Form CMS 10066)

A member who wishes to appeal the determination made by the facility or The Health Plan that inpatient care is no longer medically necessary must request an immediate review by the peer review organization (PRO) of the determination. The member must request the immediate PRO review by noon of the first working day after receipt of the notice. The member will not be financially responsible for the hospital care until the PRO makes its decision. If the admission was not authorized by The Health Plan or the admission did not constitute emergency or urgently needed care and the PRO upholds The Health Plan’s determination, the member is financially responsible for the hospital costs.

A member who fails to request an immediate PRO review may request expedited reconsideration by The Health Plan through the appeal process. Form CMS 10066

Forms and instruction can be found on the CMS website.
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 coinsurance, copayments and deductibles from those enrolled in the QMB program, including those enrolled in Medicare Advantage and other Part C Plans.

For changes from July 1, 2018, refer to the CMS MedLearn Matters article for further guidance:

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. A patient should not get a bill for medical care that Medicare covers. Patients cannot be charged for Medicare deductibles, coinsurance and copayments.

1.800.MEDICARE (1.800.633.4227).
Medicare Provider Rights and Responsibilities

It is imperative that you be aware of these rights and responsibilities as a participating provider with The Health Plan. You are expected to assist our members by making them aware of their rights and by supporting these within your practice. Please refer to this section of the manual for important information regarding CMS quality standards that you are required to meet when caring for Medicare Advantage enrollees. Customer Service is available to assist with any member issues that may arise by calling 1.877.847.7907 or visiting medicare2020.healthplan.org

Overview of Physician Responsibilities

Primary Care Physicians (PCPs):
- Act as a health care manager for members to arrange and coordinate their medical care, including but not limited to, routine care, and follow-up care after the receipt of emergency services.

Specialists:
- Provide continuity and coordination of care by sending a written report to PCPs regarding any treatment or consultation provided to members, regardless of whether the service was a result of a PCP referral or the member making his/her own arrangements.

All Contracted Physicians:
- Arrange for the provision of medical services to The Health Plan’s members by a participating practitioner after hours, on weekends, vacations, and holidays. Services from non-participating covering practitioners may not be covered, unless otherwise approved by The Health Plan.
- All physician offices must have 24-hour on-call capability, either directly or through an answering service, not an answering machine.
- Help members obtain their benefit coverage by getting written prior authorization for services that require it and prior to referring for out-of-plan services, as appropriate.
- Facilitate candid discussion with members regarding appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage. Such discussion should include complete and current information concerning a diagnosis, treatment, and prognosis, in terms that the member (or designee) can be expected to understand.
- Provide to members the information necessary to give informed consent prior to the start of any procedure or treatment.
- Maintain appropriate medical records regarding members and their treatment, recognizing that said records are confidential and ensuring that they are maintained in accordance with legal and ethical requirements concerning confidentiality and security.
- Cooperate with The Health Plan, or its designee, in the resolution of members’ complaints, expedited appeals, appeals and/or grievances.
- Comply with other administrative requirements as specified in the applicable contract or stipulated in this Provider Manual or its updates.
- Promote the efficient delivery of medical services to maximize health care resources and the member’s premium dollar and improve quality of care provided.
• Refrain from providing treatment to the physician’s own family members.

• Provide medical information in a culturally-competent manner to all members, including those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities.

**NCQA Requirements:**

• Comply with The Health Plan medical records policy, quality assurance programs, medical management programs, and HEDIS® data collection.

**CMS Marketing Guidelines:**

• Comply with [CMS Marketing Guidelines](#) for provider-based activities. The guidelines, available below, govern how providers can and cannot inform or educate patients about enrollment and plan information.
SecureCare/SecureChoice Rights and Responsibilities

An excerpt from THP’s Medicare Member Handbook

Our plan must honor your rights as a member of the plan.

We must provide information in a way that works for you (in languages other than English, in Braille, in large print, or other alternate formats, etc.)

To get information from us in a way that works for you, please call Member Services at 1.877.847.7907.

Our plan has people and free interpreter services available to answer questions from disabled and non-English speaking members. We can also give you information in Braille, large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan’s benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Member Services at 1.877.847.7907 or contact our Director of Medicare.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with The Health Plan Appeals Coordinator at 1.877.847.7907 (TTY: 711). You may also file a complaint with Medicare by calling 1.800.MEDICARE (1.800.633.4227) or directly with the Office for Civil rights. Contact information is included in the Evidence of Coverage or you may contact Member Services for additional information.

We must treat you with fairness and respect at all times

Our plan must obey laws that protect you from discrimination or unfair treatment. We do not discriminate based on a person’s race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services’ Office for Civil Rights at 1.800.368.1019 (TTY: 1.800.537.7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call us at Member Services at 1.877.847.7907. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

We must ensure that you get timely access to your covered services and drugs

As a member of our plan, you have the right to choose a primary care provider (PCP) in the plan’s network to provide and arrange for your covered services (Chapter 3 explains more about this). Call Member Services to learn which doctors are accepting new patients at 1.877.847.7907. You also have the right to go to a women’s health specialist (such as a gynecologist) without a referral.

As a plan member, you have the right to get appointments and covered services from the plan’s network of providers within a reasonable amount of time. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.
If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9, Section 10 of this booklet tells what you can do. (If we have denied coverage for your medical care or drugs and you don’t agree with our decision, Chapter 9, Section 4 tells what you can do.)

**We must protect the privacy of your personal health information**

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your “personal health information” includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a “Notice of Privacy Practice,” that tells about these rights and explains how we protect the privacy of your health information.

**How do we protect the privacy of your health information?**

- We make sure that unauthorized people don’t see or change your records.
- In most situations, if we give your health information to anyone who isn’t providing your care or paying for your care, we are required to get written permission from you first. Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
  - For example, we are required to release health information to government agencies that are checking on quality of care.
  - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

**You can see the information in your records and know how it has been shared with others**

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your healthcare provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Member Services at 1.877.847.7907.
We must give you information about the plan, its network of providers, and your covered services

As a member of SecureCare (HMO) or SecureChoice (PPO), you have the right to get several kinds of information from us. (As explained above, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.)

If you want any of the following kinds of information, please call Member Services at 1.877.847.7907:

- Information about our plan. This includes, for example, information about the plan’s financial condition. It also includes information about the number of appeals made by members and the plan’s performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.

- Information about our network providers including our network pharmacies.
  - For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
  - For a list of the providers in the plan’s network, see the Plan Provider Directory.
  - For a list of the pharmacies in the plan’s network, see the Plan Pharmacy Directory.
  - For more detailed information about our providers or pharmacies, you can call Member Services at 1.877.847.7907 or visit our website at medicare2020.healthplan.org.

- Information about your coverage and the rules you must follow when using your coverage.
  - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
  - To get the details on your Part D prescription drug coverage, see Chapters 5 and 6 of this booklet plus the plan’s List of Covered Drugs (Formulary). These chapters, together with the List of Covered Drugs (Formulary), tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
  - If you have questions about the rules or restrictions, please call Member Services at 1.877.847.7907.

- Information about why something is not covered and what you can do about it.
  - If a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network provider or pharmacy.
  - If you are not happy or if you disagree with a decision, we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 9 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 9 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
If you want to ask our plan to pay our share of a bill you have received for medical care or a Part D prescription drug, see Chapter 7 of this booklet.

- **Utilization Review.** The Health Plan has a Utilization Management Program in place that monitors the use of, or evaluates the clinical necessity, appropriateness, efficacy or efficiency of, health care services, procedures or care settings. Areas of utilization management include:
  - Prior authorization of health care services, for example elective admissions, home health services, durable medical equipment or imaging studies. Prior authorizations may be for non-urgent services, urgent services or post services. The decisions for prior authorizations are made within strict time frames to minimize any disruption in the provision of health care. Non-authorization decisions are communicated to members and providers within strict time frames with sufficient information to understand the reason for the non-authorization and to decide whether to appeal the non-authorization. Only medical directors who are physicians may not authorize services for medical necessity.
  - Hospital inpatient review—Clinical information is received from hospitals which enable registered nurses at The Health Plan to assist with post-hospital care needs and arranging services to ensure care across the continuum.
  - Care/case management is a personalized process to assess treatment options and opportunities to coordinate care, design care plans to improve quality and efficacy of care, manage cost and benefits patient care to ensure optimal outcomes for members with catastrophic illness or those needing episodic management of health care needs. Registered nurses perform the functions of utilization management.

- **New Technology**
  - The Health Plan tries to keep pace with change and ensure members have access to safe and effective care. The Health Plan continually reviews new trends in medical technology, procedures, pharmacological treatments and drugs. Scientific evidence, medical effectiveness and determinations from regulatory bodies are all components of the review of new technology. The Health Plan reviews this information to form the basis for coverage decisions in the future.

**We must support your right to make decisions about your care.**

**You have the right to know your treatment options and participate in decisions about your health care.**

You have the right to get full information from your doctors and other health care providers when you go for medical care. Your providers must explain your medical condition and your treatment choices in a way that you can understand.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- To know about all of your choices. This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
• To know about the risks. You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.

• The right to say “no.” You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.

• To receive an explanation if you are denied coverage for care. You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 9 of this booklet tells how to ask the plan for a coverage decision.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself.

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, if you want to, you can:

• Fill out a written form to give someone the legal authority to make medical decisions for you if you ever become unable to make decisions for yourself.

• Give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called “advance directives.” There are different types of advance directives and different names for them. Documents called “living will” and “power of attorney for health care” are examples of advance directives.

If you want to use an “advance directive” to give your instructions, here is what to do:

• Get the form. If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Member Services to ask for the forms at 1.877.847.7907.

• Fill it out and sign it. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.

• Give copies to appropriate people. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can’t. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital.

• If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.

• If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.
Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

**What if your instructions are not followed?**

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with Probate Court in the county in which you reside.

**You have the right to make complaints and to ask us to reconsider decisions we have made.**

If you have any problems or concerns about your covered services or care, Chapter 9 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints. What you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – we are required to treat you fairly.

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Member Services at 1.877.847.7907.

**What can you do if you believe you are being treated unfairly or your rights are not being respected?**

**If it is about discrimination, call the Office for Civil Rights.**

If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services’ Office for Civil Rights at 1.800.368.1019 or TTY 1.800.537.7697, or call your local Office for Civil Rights.

**Is it about something else?**

If you believe you have been treated unfairly or your rights have not been respected, and it’s not about discrimination, you can get help dealing with the problem you are having:

- You can call Member Services at 1.877.847.7907.
- You can call the State Health Insurance Assistance Program. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- Or, you can call Medicare at 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.

**How to get more information about your rights**

There are several places where you can get more information about your rights:

- You can call Member Services (phone numbers are printed on the back cover of this booklet).
- You can call the SHIP. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact Medicare.
  - Visit the Medicare website to read or download “Your Medicare Rights & Protections”
  - Call 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week (TTY:1.877.486.2048)
You have some responsibilities as a member of the plan.

What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call Member Services at 1.877.847.7907. We’re here to help.

- Get familiar with your covered services and the rules you must follow to get these covered services. Use this Evidence of Coverage booklet to learn what is covered for you and the rules you need to follow to get your covered services.
  - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
  - Chapters 5 and 6 give the details about your coverage for Part D prescription drugs.

- If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us. Please call Member Services at 1.877.847.7907.
  - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called “coordination of benefits” because it involves coordinating the health and drug benefits you get from our plan with any other health and drug benefits available to you. We’ll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 10.)

- Tell your doctor and other health care providers that you are enrolled in our plan. Show your plan membership card whenever you get your medical care or Part D prescription drugs.

- Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.
  - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don’t understand the answer you are given, ask again.

- Be considerate. We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor’s office, hospitals, and other offices.

- Pay what you owe. As a plan member, you are responsible for these payments:
  - You must pay your plan premiums to continue being a member of our plan.
  - In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B. For that reason, some plan members must pay a premium for Medicare Part A and most plan members must pay a premium for Medicare Part B to remain a member of the plan.
For most of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). Chapter 4 tells what you must pay for your medical services. Chapter 6 tells what you must pay for your Part D prescription drugs.

If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.

- If you disagree with our decision to deny coverage for a service or drug, you can make an appeal. Please see Chapter 9 of this booklet for information about how to make an appeal.

If you are required to pay a late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.

If you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount directly to the government to remain a member of the plan.

Tell us if you move. If you are going to move, it’s important to tell us right away. Call Member Services at 1.877.847.7907.

If you move outside of our plan service area, you cannot remain a member of our plan. (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a Special Enrollment Period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.

If you move within our service area, we still need to know so we can keep your membership record up to date and know how to contact you.

If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.

Call Member Services for help if you have questions or concerns. We also welcome any suggestions you may have for improving our plan.

- Call Member Services at 877.847.7907.

- For more information on how to reach us, including our mailing address, please see Chapter 2.

Contacting Utilization Review Staff

- During business hours 8:00 AM – 5:00 PM Monday through Friday, you may call us toll free at 1.800.624.6961, ext. 7644.

- After 5:00 PM Monday through Friday, you may call us toll free at 1.800.624.6961.
Section 5 Medicaid
Mountain Health Trust (MHT) and West Virginia Health Bridge (WVHB)

West Virginia Medicaid Programs

The Health Plan began administering health care benefits to Mountain Health Trust (MHT) members on September 1, 1996. THP currently serves all 55 counties in West Virginia.

Mountain Health Trust (MHT)/WV Health Bridge (WVHB) ID Cards and Eligibility

The MHT or WVHB member will have two ID cards: The Health Plan ID card and the WV medical card, which is sent annually from the West Virginia Department of Health and Human Resources (DHHR).

The Health Plan no longer uses the member’s social security number (SSN) as the ID number; instead a random HID is used. The member should always present both ID cards since The Health Plan does not determine eligibility. Each eligible individual family member will have a separate ID card with his/her own plan ID number. The Health Plan ID card has the MHT or WVHB logo and important lines of information:

- Member’s plan ID # including – 01 suffix (important for billing correctly)
- Medicaid number
- Member’s name
- Member’s PCP name
- PCP phone number

The Health Plan ID card is sent to the member once, unless they change PCP or lose the card and request another one.

All members, except newborns, become effective on the first of each month and could term on the last day of the month. If you have any eligibility questions, please call the Customer Service Department at 1.888.613.8385 to verify coverage or visit the secure provider portal. If you do not have access to this site, please contact:

Provider Relations – EDI Support
Phone: 1.800.624.6961, ext. 6248
Email: hpecs@healthplan.org
Fax: 740.695.7883

When medically necessary, The Health Plan makes services available 24 hours a day, seven days a week. Physicians must comply with the access standards set forth in Section 2 of the provider manual.

THP must cover out-of-network services that are otherwise covered under the Medicaid Contract for the enrollee if THP’s network is unable to provide such services. THP must ensure that the cost to the enrollee is no greater than it would be if the services were furnished within the network. Services must be covered as adequately and timely as if such services were provided within the network, and for as long as THP is unable to provide them. To the extent possible, THP must encourage out-of-network providers to coordinate with THP with respect to payment.
THP regularly measures the extent to which providers in the network comply with these requirements and take remedial action if necessary. THP must ensure that services are provided in a culturally competent manner to all enrollees, including those with limited English proficiency or reading skills, those with diverse cultural and ethnic backgrounds, the homeless, and individuals with physical and mental disabilities, regardless of gender, sexual orientation, or gender identity. THP also ensures that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities.
Mountain Health Trust ID Cards

TANF and SSI ID Card
Group number: 0140 and 0142

The THP Medicaid ID cards are color-coded blue for ease in identifying the Medicaid population. All pertinent billing information is on the card, including the members’ THP ID number and Medicaid ID number. If you have any questions, please contact our Customer Service Department at 1.888.613.8385.

TANF ID Card
Group number: 0140

SSI ID Card
Group number: 0142
**WV Health Bridge ID Cards**

The THP Medicaid ID cards are color-coded blue for ease in identifying the Medicaid population. All pertinent billing information is on the card, including the members’ THP ID number and Medicaid ID number. If you have any questions, please contact our Customer Service Department at 1.888.613.8385.

**WV Health Bridge Card**

Group number: 0141
### Medicaid Benefits and Exclusions at a Glance

<table>
<thead>
<tr>
<th>Mountain Health Trust &amp; West Virginia Health Bridge Covered Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical</strong></td>
</tr>
<tr>
<td>• Primary Care/Specialist Office Visits/FQHC/RHC— Includes physician, physician assistant, nurse practitioner and nurse midwife services.</td>
</tr>
<tr>
<td>• Physician Services— Certain services may require prior authorization or have service limits. May be delivered through telehealth.</td>
</tr>
<tr>
<td>• Laboratory and X-ray Services— Includes lab services related to substance abuse treatment. Services must be ordered by a physician and certain procedures have service limits. Genetic testing requires prior authorization.</td>
</tr>
<tr>
<td>• Clinics— Includes general clinics, birthing centers, and health department clinics. Vaccinations are included for children.</td>
</tr>
<tr>
<td><strong>Hospital</strong></td>
</tr>
<tr>
<td>• Inpatient— Includes all inpatient services (including including long-term acute care (LTAC), bariatric and corneal transplants). Transplant services must be in a center approved by Medicare and Medicaid and covered under fee-for-service. Requires prior authorization.</td>
</tr>
<tr>
<td>• Organ and Tissue Transplants— Corneal transplants only.</td>
</tr>
<tr>
<td>• Outpatient— Includes preventative, diagnostic, therapeutic, all emergency services, and rehabilitative medical services.</td>
</tr>
<tr>
<td><strong>Ambulatory Surgical Care</strong></td>
</tr>
<tr>
<td>• Includes services and equipment for surgical procedures.</td>
</tr>
<tr>
<td><strong>Emergency</strong></td>
</tr>
<tr>
<td>• Post-stabilization— Includes care after an emergency health condition is under control. Care provided in a hospital or other setting.</td>
</tr>
<tr>
<td>• Emergency Transportation— Includes ambulance and air ambulance. Out-of-state requires prior authorization.</td>
</tr>
<tr>
<td><strong>Rehabilitation</strong></td>
</tr>
<tr>
<td>• Pulmonary Rehabilitation— Includes procedures to increase strength of respiratory muscle and functions. Must meet plan guidelines. Maximum of 12 weeks or 36 visits per calendar year.</td>
</tr>
<tr>
<td>• Cardiac Rehabilitation— Includes supervised exercise sessions with EKG monitoring. Limited to a maximum of 12 weeks or 36 visits per heart attack or heart surgery.</td>
</tr>
<tr>
<td>• Inpatient Rehabilitation— Services related to inpatient facilities that provide rehabilitation services for Medicaid eligible individuals (in a rehabilitation facility; limited to 60 days per calendar year). Not covered for adults over the age of 21. Requires prior authorization.</td>
</tr>
</tbody>
</table>
Specialty
- **Podiatry**—Includes treatment of acute conditions for children and adults. Includes some surgeries, reduction of fractures and other injuries, and orthotics. Routine foot care is not covered. Surgical procedures other than in-office require prior authorization.
- **Physical and Occupational Therapy**—Combined 20 visits per year for habilitative and rehabilitative services. Prior Authorization required on the 21st visit.
- **Speech Therapy**—For children (ages 0-21): Prior authorization required. The benefit limit is 20 visits per calendar year. For adults (21 and older): Limited to specific medical/surgical conditions and prior authorization is required.
- **Chiropractor**—Limited to manual manipulation of the spine and X-ray exam related to service. Prior authorization required on the 21st visit per calendar year.
- **Handicapped Children’s Services/Children with Special Health Care Needs Services**—Includes coordinated services and limited medical services, equipment and suppliers (for children only).
- **Nutritionist**—Medical nutritionist visits are limited to six visits per calendar year. Medical nutritionist visits for weight loss only if part of evaluation for bariatric surgery requires prior authorization.

Preventive Care and Disease Management
- **EPSDT**—(ages 0-21) Includes health care services for any medical or psychological condition discovered during screening (for children only). Needs that are identified that are over the allowable or not included in the covered services require prior authorization.
- **Tobacco Cessation**—Includes therapy, counseling, and services. Guidance and risk-reduction counseling covered for children.
- **Sexually Transmitted Disease Services**—Includes screening for a sexually transmitted disease from your PCP or a specialist in our network.
- **Preventive Screenings**
  - Annual pap smear for cervical cancer screening beginning at age 18, earlier if medically necessary.
  - Mammography screening: Ages 35-39 at least once, 40-49 every two years unless medically determined that member is at risk, one every year and 50+ one every year.
  - Prostate cancer screening: Beginning at age 50.
  - Colorectal screening: Age 50 and older without symptoms or under age 50 with symptoms.

Maternity
- **Right From The Start**—Includes prenatal care and care coordination. Services covered through 60-day post-partum and infants less than one year old.
- **Family Planning**—Services to aid recipients of childbearing age to voluntarily control family size or to avoid or delay an initial pregnancy. Pregnancy terminations and infertility treatments are not covered. Tubal ligations are the responsibility of fee for service.
- **Maternity Care**—Includes prenatal, inpatient hospital stays during delivery, and post-partum care. Home birth is not covered.

Durable Medical Equipment, Orthotics and Prosthetics
- Requires prior authorization and must meet The Health Plan guidelines.
- Limited replacements.
- Other limitations may apply.
<table>
<thead>
<tr>
<th><strong>Hospice</strong></th>
<th>Requires prior authorization for all visits. If you revoke three times, you are no longer eligible for hospice. For adults, rights are waived to other Medicaid services related to the terminal illness.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Home Health Care</strong></th>
<th>Covered for nursing, physical therapy, occupational therapy, and speech therapy. Includes services given at member’s residence. This does not include a hospital nursing facility, ICF/MR, or state institutions. Prior authorization required prior to 2nd certification period.</th>
</tr>
</thead>
</table>

| **Dental** | For children (ages 0-21)  
- Must use participating practitioners (see provider directory or call Skygen Dental).  
- Orthodontics covered for the entire duration of treatment regardless of loss of eligibility. Requires prior authorization.  
For adults (21 and older)  
- Adults covered only for accident or injury, tumor removal, or emergency extraction.  
- TMJ is not covered for adults. |
| --- | --- |

| **Vision** | For children (ages 0–21)  
- Must use participating vision services practitioners. See provider directory or call Superior Vision.  
- Vision screening and therapy.  
- One eye exam covered once every 12 months.  
- Limited one frame per year.  
- Contact lenses covered for certain diagnoses.  
- Repairs.  
For adults (21 and older)  
- Adults limited to medical treatment only.  
- Medical contact lenses for adults and children covered for certain diagnoses.  
- One pair of glasses up to 60 days after cataract surgery. |
| --- | --- |

<table>
<thead>
<tr>
<th><strong>Diabetes Management</strong></th>
<th>Members diagnosed with diabetes have the right to access vision services without a PCP referral for an annual examination. If annual exam reveals abnormal conditions, any follow-up appointment with a specialist will require prior authorization from the member’s PCP.</th>
</tr>
</thead>
</table>

| **Hearing** | For children (ages 0–21)  
- Requires prior authorization.  
- Audiology screening (only if referred by a PCP or ENT practitioner).  
- One hearing aid every five years.  
- Hearing aid evaluations, hearing aid supplies, batteries, and repairs. Certain procedures may have service limits or require prior authorization. Augmentation communication devices limited to children under 21 years of age and require prior approval.  
For adults (21 and older)  
- Requires prior authorization.  
- Covered for specific medical conditions. |
| --- | --- |
**Behavioral Health**

- **Behavioral Health Rehabilitation/Psychiatric Residential Treatment Facility** – Includes services for children (up to age 21) with mental illness and substance use disorder. Limited frequency and amount of services. Certain services require prior authorization. Children’s residential treatment is not covered.

- **Inpatient Psychiatric Services under age 21** – Includes behavioral health and substance use disorder hospital stays at a psychiatric hospital or a distinct part psychiatric unit of an acute care hospital. Requires prior authorization. Children’s residential treatment is not covered.

- **Inpatient Psychiatric Services for ages 21-64** – Includes behavioral health and substance use disorder hospital stays at a psychiatric hospital or a distinct part psychiatric unit of an acute care hospital. Requires prior authorization.

- **Outpatient** – Includes services for individuals with mental illness and substance use disorder. Providers of ACT and IOP must be certified by the BMS. Certain services require prior authorization. Most services may be provided by telehealth.

- **Psychological** – Testing. Some evaluation and testing procedures have frequency restrictions. Certain services require prior authorization.

- **Drug Screening** – Laboratory services to screen for presence of one or more drugs of use. Limits apply and prior authorization is required for some testing.

- **Substance Use Disorder (SUD) Services** – Targeted case management, residential services, peer recovery support services and counseling services to treat those with substance use disorder. Prior authorization is required for some services.

*There are additional services to those included on this list. If you have questions on whether a service is covered, look at the section of the handbook that explains what Medicaid covers or give us a call.*
### Benefits Under Fee-for-Service Medicaid

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortion</td>
<td>Includes drugs, devices, and procedures for termination of ectopic pregnancy. Physician certification required.</td>
</tr>
<tr>
<td>Early Intervention Services for Children Three and Under</td>
<td>Includes doctor and hospital charges</td>
</tr>
<tr>
<td>Tubal ligations</td>
<td>Includes nursing, social services, and therapy.</td>
</tr>
<tr>
<td>Nursing Facility Services</td>
<td>Includes nursing, social services, and therapy.</td>
</tr>
<tr>
<td>Personal Care Services</td>
<td>Includes personal hygiene, dressing, feeding, nutrition, environmental support, and health-related functions. May not exceed 60 hours per month without prior authorization.</td>
</tr>
<tr>
<td>Personal Care for Aged/Disabled</td>
<td>Includes assistance with daily living in a community living arrangement, grooming, hygiene, nutrition, physical assistance, and environmental for individuals in the Age/ Disabled Waiver. Limited on per unit per month basis. Requires physician order and nursing plan of care.</td>
</tr>
<tr>
<td>ICF/MR Intermediate Care Facility</td>
<td>Includes physician and nursing services, dental, vision, hearing, lab, dietary, recreational, social services, psychological, habilitation, and active treatment for the mentally retarded. Requires physician or psychiatrist certification.</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>Includes dispensed on an ambulatory basis by a pharmacy, family planning supplies, diabetic supplies, vitamins for children, and prenatal vitamins. Hemophilia blood factor, Hepatitis-C, weight gain, cosmetic, hair growth, fertility, less than effective, and experimental drugs are not covered. Drugs dispensed by a physician at no cost are not covered.</td>
</tr>
<tr>
<td>Organ Transplant Services</td>
<td>Generally safe, effective, medically necessary transplants covered when no alternative is available. Cannot be used for investigational/ research nature or for end-stage diseases. Must be used to manage disease.</td>
</tr>
<tr>
<td>School-based Services</td>
<td>Service limitations are listed in the fee for service Medicaid provider manual.</td>
</tr>
<tr>
<td>Transportation</td>
<td>Includes multi-passenger van services and common carriers (public railways, buses, cabs, airlines, ambulance as appropriate, and private vehicle transportation). Prior authorization is required by county DHHR staff. To get transportation, call: 1.844.549.8353.</td>
</tr>
</tbody>
</table>

### Exclusions

Some services are not available through The Health Plan or Medicaid. If you choose to get these services, you may have to pay the entire cost of the service. The Health Plan is not responsible for paying for these services and others:

- All non-medically necessary services.
- Except in an emergency, inpatient hospital tests that are not ordered by the attending physician or other licensed practitioner, acting within the scope of practices, who is responsible for the diagnosis or treatment of a particular patient’s condition.
- Organ transplants, except in some instances.
- Cosmetic/plastic surgery will be covered only to correct conditions from accidents/injuries like a car accident and birth defects like a cleft lip. Breast implants are covered only for mastectomy due to breast cancer or fibrocystic breast disease. You may have to get a second opinion before getting these services.
Exclusions, continued

- Removal/replacement of breast implants must be proven medically necessary. Implants must have been inserted for reconstructive purposes due to mastectomy for breast cancer or fibrocystic breast disease. You may have to get a second opinion before getting these services.
- These conditions must have happened while you were a member of The Health Plan. If not, The Health Plan must determine an ongoing history of medically necessary cosmetic/plastic surgery to correct these conditions. The Health Plan may do so by looking at your past medical records.
- Removal of breast implants that were inserted for cosmetic reasons only will not be covered.
- Oral surgery for adults will be covered to correct conditions from accidents/injuries, like a car accident. The accident/injury must have happened while you were a member of The Health Plan. An oral surgeon must be needed to correct these conditions. These services must start within six months of the accident/injury.
- **REMEMBER** – no other dental problems will be covered for adults such as plates, crowns, bridges, etc. (even TMJ when caused by an accident/injury). Practitioner services for non-covered dental problems will be covered when it is medically necessary and appropriate for you to go to the practitioner to get the services. Bills for the oral surgeon or dentist will not be covered for adults.
- Custodial or home care, rest and respite care, or other services primarily to assist in the activities of daily living and personal comfort items (to include cleansing and luxury items) are not paid for by The Health Plan. This includes personal services and residential services.
- Health care that is for research, investigation, or experimental as determined by The Health Plan, is not paid for by The Health Plan. The Health Plan will look at standards of the AMA, FDA, NIH, Medicare, or reports of consultants to decide if a health care treatment is experimental or investigational.
- Services based on religious beliefs are not paid for by The Health Plan.
- Private rooms are not paid for, except when medically needed and approved by The Health Plan. Personal or comfort items and services like guest meals, lodging, radio, television, and telephone are not paid for by The Health Plan.
- Hospital or medical care for problems that state or local law requires treatment of in a public facility is not paid for by The Health Plan.
- Any injury or sickness when any benefits, settlements, awards, or damages will be received or paid will not be paid for by The Health Plan. This includes workers’ comp, employer’s liability or similar law or act. This applies even if you waived your rights to workers’ comp, employer’s liability, or similar laws or acts. Be sure to tell The Health Plan if you will get any benefits, settlements, awards, damages, or workers’ comp.
- Reversal of voluntary sterilization and associated services and/or expenses will not be paid for by The Health Plan.
- Sterilization for members under age 21 will not be paid for by The Health Plan.
Exclusions, continued

- Sex change, hormone therapy for sex transformation, and gender transition procedures/expenses will not be paid for by The Health Plan. Procedures, services and supplies related to sexual dysfunction will not be paid for by The Health Plan.

- Special services not approved by The Health Plan will not be paid for.

- Provider and medical services outside the service area will not be paid for if you knew you would need these services before you left the service area. If you know you will need services and you may be traveling soon, tell your PCP or The Health Plan.

- Hearing aid evaluations, bone-anchored hearing aids, cochlear implants, hearing aids, hearing aid supplies, batteries and repairs will only be covered for members under the age of 21. Coverage depends on hearing loss and The Health Plan guidelines.

- Exams for insurance, sports physicals, camp physicals, or daycare physicals will not be paid for unless it is part of your yearly physical exam given by your PCP.

- Medical and surgical treatment for all infertility services will not be paid for by The Health Plan.

- Abortions will not be paid for by The Health Plan but are covered by FFS Medicaid. Use your medical card.

- Long-term cardiac and pulmonary, physical, respiratory, occupational or speech therapy will only be paid for in certain situations, such as for children.

- Services for acupressure, hypnosis, electrolysis, Christian Science treatment and autopsy. Any education or training classes including Lamaze and to quit tobacco use (unless under RFTS) will not be paid for by The Health Plan. Estrogen and androgen pellet implants, arch supports, massage, and paternity testing are not covered.

- Liposuction, panniculectomies or abdominoplasty, such as surgery to remove fatty tissue ("tummy tucks"), will not be covered by The Health Plan.

- Work hardening programs, including functional capacity evaluations will not be covered by The Health Plan.

- Services at non-medical weight loss clinics and diet centers, mini-gastric bypass surgery, and gastric balloon for treatment of obesity will not be covered by The Health Plan. Consideration for bariatric surgery and related services require prior authorization. Also included are wiring of the jaw, weight control programs, screening for weight control programs, and similar services.

- Organ transplants and related expenses will not be covered by The Health Plan. These are covered by FFS Medicaid through your medical card.

- Vision services for members over age 21 are limited to medical treatment only and require an approved referral to a participating ophthalmologist.

- Practitioner and medical services that are not medically necessary or appropriate as determined by The Health Plan will not be paid for.

- Other limitations specifically stated in the provider and medical benefits list in this handbook.
Exclusions, continued

- Services not provided, arranged, or authorized by your practitioner, except in an emergency or when allowed in this policy. Elective pre-surgery testing on an inpatient basis without the authorization of The Health Plan’s medical director.
- Sports-related devices will not be paid for by The Health Plan.
- Acupuncture will not be paid for by The Health Plan, unless it is for anesthesia used with a covered procedure.
- Services by a practitioner with the same legal address or who is a member of the covered person’s family will not be paid for by The Health Plan. This includes spouse, brothers, sisters, parents or children.
- Unlicensed services by a practitioner will not be paid for by The Health Plan.
- War-related injuries or treatment in a state or federal provider for military or service-related injuries or disabilities will not be paid for by The Health Plan.
- Non-medical services related to the treatment of temporomandibular joint dysfunction (TMJ) or craniomandibular joint dysfunction (CMD) will not be paid for by The Health Plan. WV Medicaid covers TMJ for children up to age 21.
- If a member decides to get hospice services instead of medical treatment, he/she gives up the right to other Mountain Health Trust or West Virginia Health Bridge services for the terminal illness. Coverage continues for other medical conditions not related to the terminal illness.
- Sterilization of a mentally incompetent or institutionalized person will not be paid for by The Health Plan.
- Inpatient tests not ordered by the attending practitioner or other licensed practitioner will not be paid for by The Health Plan, except in cases of emergency.
- Therapy and related services for a patient showing no progress will not be paid for by The Health Plan. Speech therapy for members ages 0-21 must meet criteria and be pre-authorized. Speech therapy for adults is not a covered benefit except when medically needed as a result of specific medical/surgical conditions such as ALS, cerebral palsy, stroke, or physical trauma.
- Non-emergency transportation is not covered by The Health Plan but is covered by FFS Medicaid. Use your medical card to get this service.
- Services that, in the judgment of your practitioner, are not medically appropriate or not required by accepted standards of medical practice or the plan rules governing services.
- Megavitamin therapy and nutrition-based therapy will not be paid for by The Health Plan.
- Services performed after your physician has advised the member that further services are not medically appropriate or not covered services will not be paid for by The Health Plan.
- Homeopathic treatments will not be paid for by The Health Plan.
- Treatment for flat foot and subluxation of the foot are not covered.
- Services related to moral or religious objections are not covered.

This is not a complete list of the services that are not covered by The Health Plan. If a service is not covered, not authorized, or is provided by an out-of-network provider, you may have to pay. If you have a question about whether a service is covered, please call Member Services at 1.888.613.8385.
## Additional Resources for Medicaid Members

<table>
<thead>
<tr>
<th>Program</th>
<th>Description</th>
<th>Contact Information</th>
</tr>
</thead>
</table>
| Tobacco Cessation                                 | • The Health Plan’s nationally certified ALA (American Lung Association) tobacco cessation facilitator engages and educates the member to assist in developing a member specific tobacco quit plan.  
The program addresses:  o Developing a plan to quit  o Getting support and encouragement  o Learning new skills and behaviors  o Getting medication, if necessary, to assist with quitting and how to take it correctly  o Preparing for relapse and difficult situations | 1.888.613.8385          |
| Free Cell Phones for Medicaid Members             | • THP has partnered with SafeLink to offer the LifeLine program to our members at no cost. Members receive:  o A smartphone with 1GB data and 1,000 monthly minutes  o Unlimited text  o Free calls to The Health Plan | 1.877.631.2550  
www.safelink.com  
Promo code: THPWV |
| Non-Emergent Transportation                       | • Members with Medicaid may be eligible for transportation services  
• Members can contact NEMT broker to schedule a reservation                                                                                                                                   | 1.844.549.8353          |
| Right From The Start Program (RFTS)               | • Statewide program that helps WV mothers and their babies lead healthier lives by offering home visitation services with a designated coordinator (RN or LSW)                                               | www.wvdhhr.org/rfts     |
| West Virginia Birth to Three Program              | • WV Birth to Three services are administered by the West Virginia Department of Health and Human Resources, Bureau for Public Health, Office of Maternal, Child and Family Health in cooperation with the Early Intervention Interagency Coordinating Council (ICC) | 1.304.558.5388          |
| Children’s with Special Healthcare Needs (CSHCN) | • CSHCHN Program was created to assist families who have children with conditions that need special care                                                                                           | 1.304.558.5388          |
| Teladoc                                           | • 24/7/365 access to providers for non-emergent issues                                                                                                                                             | 1.800.TELADOC (835-2362) |
Hours of Operation

Providers must ensure that the hours of operation for members are convenient, do not discriminate against enrollees, and are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee for service. The provider must ensure that waiting times at sites of care are kept to a minimum and ensure that the waiting time standard for Medicaid enrollees is the same standard used for commercial enrollees. Providers cannot discriminate against Medicaid enrollees in the order that patients are seen or in the order that appointments are given (providers are not permitted to schedule Medicaid-only days).

Cultural Competence

Providers are required to perform healthcare services in a culturally competent manner to all members. This includes members with limited English proficiency or reading skills, those with diverse cultural and ethnic backgrounds, the homeless, and individuals with physical and mental disabilities, regardless of gender, sexual orientation, or gender identity.

To ensure that providers provide services in a culturally competent manner, THP has developed training materials related to cultural competence and social determinants of health. The Cultural Competency/Social Determinants of Health Training for Providers PowerPoint presentation and attestation form may be accessed on THP’s provider portal under “Resource Library,” “Training and Education.” Cultural competency training is noted by THP’s provider engagement representatives during provider on-site surveys. Provider engagement representatives will conduct provider training upon request.

EPSDT

Early and periodic screening, diagnosis, and treatment (EPSDT): Medically necessary services, including interperiodic and periodic screenings, listed in section 1905(a) of the Social Security Act. EPSDT entitles Medicaid-eligible infants, children, and adolescents to any treatment or procedure that fits within any of the categories of Medicaid-covered services listed in section 1905(a) of the Social Security Act if that treatment or service is necessary to “correct or ameliorate” defects and physical and mental illnesses or conditions. EPSDT services should be provided to all children and young adults up to age 21. The provider should do the screening (periodic, comprehensive child health assessments) to all eligible enrollees. These should be regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth.

At a minimum, these screenings must include, but are not limited to:

1. A comprehensive health and developmental history (including assessment of both physical and mental health development);
2. An unclothed physical exam;
3. Laboratory tests (including blood lead screening appropriate for age and risk factors);
4. Vision testing;
5. Appropriate immunizations, in accordance with the schedule for pediatric vaccines established by the advisory committee on immunization practices;
6. Hearing testing;
7. Dental services (furnished by direct referral to a dentist for children beginning six months after the first tooth erupts or by 12 months of age);
8. Behavioral health screening; and
9. Health education (including anticipatory guidance).

It is important that the provider documents all of the above on the member’s chart as well as referrals. The provider should submit a 1500 claim form with the appropriate codes/modifiers for services rendered to The Health Plan for reimbursement. EPSDT claims are paid without any coordination of benefits. Further information regarding EPSDT, current EPSDT forms and periodicity guidelines can be found on the following websites:

- dhhr.wv.gov/HealthCheck/providerinfo/Pages/default.aspx
- dhhr.wv.gov/bms/Pages/Chapter-519-Practitioner-Services.aspx

The Health Plan sends a monthly notice to the PCP with the list of his/her patients(s) that are expected to have a well-child exam during that month. If the member is not a patient of that PCP, the sheet should be returned to The Health Plan and marked accordingly in order to correct the records.

REMEMBER, THESE DATES ARE FOR WELL-CHILD EXAMS. If the provider does a well-child exam at the same time as a sick visit, please use the appropriate codes.

The Health Plan also sends a reminder notice to appropriate members each month that a well-child exam is due.
Copays

Medicaid members have copays for some services. The following copays apply:

<table>
<thead>
<tr>
<th>Service</th>
<th>Tier 1 (Up to 50% FPL)</th>
<th>Tier 2 (50.01 to 100% FPL)</th>
<th>Tier 3 (100.01% of FPL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient hospital (acute care 11x)</td>
<td>$0</td>
<td>$35</td>
<td>$75</td>
</tr>
<tr>
<td>Office visit (physicians and nurse practitioners)</td>
<td>$0</td>
<td>$2</td>
<td>$4</td>
</tr>
<tr>
<td>Non-emergency use of emergency department hospital only</td>
<td>$8</td>
<td>$8</td>
<td>$8</td>
</tr>
<tr>
<td>Any outpatient surgical services rendered in a physician’s office, ASC or outpatient hospital, excluding emergency rooms</td>
<td>$0</td>
<td>$2</td>
<td>$4</td>
</tr>
</tbody>
</table>

Member and providers can access copay and member eligibility information through the WV Medicaid Fiscal Agents AVRS system by calling 1.888.483.0793.

**Maximum Out-of-Pocket (OOP):**

Each calendar year quarter, members will have a maximum out-of-pocket (OOP) payment. The OOP is the most the member will ever be required to pay in any given quarter regardless of the number of health care services received. The following table shows the OOP for each tier level.

<table>
<thead>
<tr>
<th>Tier Level</th>
<th>Out-of-Pocket Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (Up to 50% FPL)</td>
<td>$8</td>
</tr>
<tr>
<td>2 (50.01 - 100% FPL)</td>
<td>$71</td>
</tr>
<tr>
<td>3 (100.01% FPL and above)</td>
<td>$143</td>
</tr>
</tbody>
</table>

Calendar quarters are as follows:
- January 1 – March 31
- April 1 – June 30
- July 1 – September 30
- October 1 – December 31
Exemptions:
The following populations and services are exempt from copays:
- Pregnant women, including pregnancy-related services up to 60 days postpartum;
- Native American and Alaska natives;
- Intermediate care facility or MR services;
- Provider-preventable services;
- Individuals in nursing homes;
- Receiving hospice services;
- Medicaid waiver services, or covered through the breast and cervical cancer treatment program;
- Family planning services and emergency services.

Medicaid Out-of-Network Non-Patient Facing Provider Reimbursement

Effective August 1, 2019, services rendered by out-of-network non-patient facing providers will only be reimbursed if an authorization is obtained prior to the service being conducted.

Reimbursement for services prior authorized to out-of-network non-patient facing providers will be at 80% of the current WV Medicaid fee schedule.

Failure to obtain prior authorization for any service performed by an out-of-network non-patient facing provider will result in claim denial.

Under federal law, the Medicaid program prohibits balance billing by all practitioners, regardless of location. All out-of-network practitioners’ claims for providing non-emergency medical services will be denied unless the services have been prior authorized.

Emergency out-of-network Medicaid-covered services are eligible for reimbursement. The documentation provided with the claim must clearly indicate an emergency situation existed.

The Health Plan may pay for covered services due to out-of-network hospital transfers if:
- Medically necessary services are not available in plan.
- WV Medicaid members are traveling outside the state and need emergency medical treatment.
- Services have been pre-approved by The Health Plan.

For documented emergencies, the member may be admitted without prior approval in-network or out-of-network, but the request for authorization and documentation must be submitted within 24 hours of admission.
Prescription Benefit

Pharmacy services for WV Medicaid managed care organization (MCO) members are administered by the traditional fee-for-service pharmacy program. All prescriptions should be billed with the information below:

- BIN 610164
- PCN DRWVPROMO

Questions regarding claims processing should be directed to the Medicaid Fiscal Agent’s POS Pharmacy Help Desk at 1.888.483.0801. Vendor specification document can be found on the West Virginia Medicaid Management Information System website for further information regarding claims processing.

Family Planning

Family planning services may be obtained by a Medicaid member without a referral or prior authorization through any Medicaid family planning provider, regardless if they are in The Health Plan network or not. Family planning services are defined as those services provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy.

These services include:

- Health education and counseling necessary to make informed choices and understand contraceptive methods
- History and physical exam
- Pap smear and lab tests if medically indicated as part of the decision-making process for choice of contraceptive methods
- Diagnosis and treatment of sexually transmitted diseases (STD) if medically indicated
- Screening, testing, and counseling of at-risk individuals for human immunodeficiency virus (HIV) and referral for treatment
- Follow-up and care for complications associated with contraceptive methods issued by the family planning provider
- Provisions for contraceptive pills, devices, and supplies (Depo-Provera injections are permissible, prescriptions are to be issued for contraceptive pills)
- Tubal ligation and vasectomies (consent forms required)
- Pregnancy testing and counseling
- Family planning provided at postpartum visits and/or discharge post-delivery (postpartum care should be provided within eight weeks of delivery)
Local Health Departments

The Health Plan contracts with local West Virginia Health Departments to provide certain services for the Medicaid programs without a referral. These services include:

- All sexually transmitted disease (STD) services including screening, diagnosis, and treatment
- HIV services including screening and diagnostic studies
- Tuberculosis services including screening, diagnosis, and treatment
- Childhood immunizations
- Family planning
- HealthCheck

The Health Department should forward all records to the member's PCP and/or OB/GYN provider.

Environmental lead assessments for THP children with elevated blood levels will be reimbursed directly by the State Bureau for Public Health. THP is responsible for the blood lead screenings.

Staffing

Staffing for the Medicaid program consists of senior management, vice president of Medicaid, Medicaid operations director, Medicaid managers and supervisors, an appeals coordinator, customer service representatives and claims analysts. The vice president is responsible for coordinating programs between The Health Plan and WV Medicaid to assure compliance with the program, as well as ongoing education to MHT and WVHB members.

There are outreach representatives who are under the direct supervision of the director. The outreach representatives are responsible for ongoing education of MHT and WVHB members.

The Health Plan will ensure that follow-up and outreach contacts are initiated for missed appointments and failure to follow medical treatment plans.

A provider should notify The Health Plan that a member is not keeping scheduled appointments, not following the medical treatment plan, the member’s behavior in the waiting room was inappropriate, or any other reason in which the member could benefit from redirection of behavior. The provider should document his/her chart accordingly. This documentation should be provided to The Health Plan after a member misses a second appointment.

Outreach representatives will then contact the member to discuss the situation, suggest alternate methods, and otherwise educate, especially to follow the provider’s treatment plan. If transportation is the problem, members should be referred to the state's transportation vendor for non-emergency transportation assistance. The member needs to understand that the provider can ask for his/her removal from his/her roster if this noncompliance persists. Please call the Medicaid Unit at 1.855.577.7124 for an outreach representative to educate the member about these issues.

MHT and WVHB members are continually educated about appropriate use of the emergency room. If members present to the ER for non-emergency cases, they may be responsible for the cost of the ER visit or a copay. The PCP should be contacted first for instructions, day or night. If it is a life-threatening situation, the member can call 911 or go to the closest ER but still call the PCP and The Health Plan within 48 hours after going to the ER. Follow-up care and treatment, including the removal of stitches, casts, and dressings must be given or arranged by the PCP.
Surgical Consent Forms

The Health Plan, in accordance with the WV Medicaid guidelines, will continue to require the completion of the state surgical consent forms for the following procedures:

- Hysterectomy
- Voluntary sterilizations (male or female)
- Pregnancy termination

The surgical consent forms for voluntary sterilizations must be completed and signed by the Medicaid member 30 days prior to the surgery. The consent form is valid for 180 days. Please note that none of the consent forms need to be submitted to The Health Plan but should remain with the member’s medical records.
Pregnancy and Newborn Enrollment

In accordance with the state of West Virginia requirements to effectively monitor and/or provide appropriate intervention during the member’s antepartum, delivery, and postpartum period, The Health Plan has elected to adopt the state’s guidelines. The Health Plan will continue to require all providers rendering services for antepartum care to submit the appropriate code for each encounter during the antepartum period that will be separately reimbursed. The Health Plan will also require separate billing for the delivery and postpartum services by submitting the appropriate CPT code(s).

The Health Plan requires the completion of the prenatal risk screening instrument (PRSI) upon the initial encounter when the EDC date is determined for all MHT and WVHB members receiving maternity services. Physicians are asked to complete the prenatal risk screening form and fax it to The Health Plan at 740.695.5297 or complete the prenatal risk screen form located on the Provider website.

The most recent version of the PRSI is available [here](#) and can be found on the WV DHHR’s Office of Maternal, Child and Family Health website.

Based on this screening tool, members are contacted to begin tracking their pregnancy. An initial prenatal care visit must be scheduled within 14 days of the date on which a Medicaid woman is found to be pregnant. Any member who has a high-risk pregnancy will be referred to the prenatal care coordinators who are nurses with obstetrics experience. If the member smokes, she is also referred to the tobacco cessation program. Outreach representatives monitor the low-risk pregnancies on a trimester basis. Members are encouraged to participate with the Women, Infant, and Children’s (WIC) program.

When The Health Plan MHT or WVHB member gives birth, her newborn(s) is automatically covered from date of birth. The enrollment specialist calls new mothers in the hospital to enroll the newborn(s) into The Health Plan. The new mother is reminded to apply for a SSN for the newborn and to select a PCP for the baby. The importance of well-child visits and immunizations are stressed. The new mother will receive a newborn packet from The Health Plan along with the baby’s ID card.

Members are encouraged to sign the baby up for the WIC program. The Health Plan ID card with the PCP listed is sent to the newborn. There is a process in place to get the newborn a Medicaid number within 30 days. If you need a newborn’s ID number please call 1.855.577.7124, but please allow 10 business days from the baby’s birth.

The new mother is also reminded of the importance of her own postpartum checkup that should occur within eight weeks of delivery. The outreach representative makes a postnatal follow-up call. She also does an initial newborn follow-up at that time. During the postnatal contact, the Edinburgh postnatal depression scale (EPDS) is reviewed for postpartum depression. If the member has a high score, she is referred to The Health Plan prenatal care coordinators who notify the member’s OB provider.

Members can qualify for THP’s postnatal incentive plan by going to their postnatal appointment within 7-84 days after delivery.
Women’s Access to Health Care

In accordance with the Women’s Health and Cancer Rights Act of 1998, The Health Plan covers reconstructive surgery after a mastectomy under the same terms and conditions as other regular inpatient services under the Plan, and will include:

- Coverage for reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Coverage for prostheses and physical complications of all stages of the mastectomy, including lymph edema.

This is all handled in a manner determined in consultation with the attending physician and the patient and approved by The Health Plan as medically necessary and appropriate.

The Health Plan allows women to have direct access to a range of women’s health care providers, including obstetricians/gynecologists, advanced nurse practitioners, certified nurse midwives, and physician assistants. This information is disclosed to members in the Member Handbook.

An annual pap test and physical breast exam is encouraged for each member and may be done by the PCP and/or OB/GYN.

Tobacco Cessation

Members are encouraged to participate in The Health Plan’s sponsored tobacco cessation classes free of charge. A friendly staff member will provide the member with one-on-one personal support that can help him/her quit.

Diabetes

Insulin pumps are covered in specific medical cases. Diet management and education are covered as part of the diabetes disease management program. Blood glucose monitors are covered for members who are diabetic when a participating provider writes the order and the monitor is obtained from a participating provider.

Members with diabetes should have an annual health assessment, dilated eye exam, kidney testing, and fasting lipid profile. Quarterly visits are encouraged for foot exams, HbA1c, blood pressure, and diabetes education. The Health Plan sends members with diabetes a yearly coupon as a reminder to have the dilated eye exam.
Medicaid Behavioral Health Services

THP is required to provide behavioral health services as outlined in the Bureau for Medical Services (BMS) provider manual to WV Medicaid members enrolled with THP. BMS’ provider manual may be accessed on the WV DHHR website.

The following chapters of the manual provide detailed information regarding services typically provided by behavioral health providers:

- Chapter 503: Licensed Behavioral Health Centers
- Chapter 504 Substance Use Disorders Services
- Chapter 510 Hospital Services
- Chapter 519: Practitioner Services
- Chapter 521: Behavioral Health Outpatient Services
- Chapter 522: Federally Qualified Health Centers and Rural Health Centers Services
- Chapter 523: Targeted Case Management and
- Chapter 531: Psychiatric Residential Treatment Facilities for Children Under 21

Note that while THP will cover behavioral health services as required by BMS, THP and BMS may have differing prior authorization requirements. Please refer to the following list of behavioral health services that are reimbursable by THP. The chart explains the unit of service, if it is available via telehealth, if prior authorization is required, and any qualifying conditions that must be met.

Contact THP’s Clinical Services Department at 1.877.221.9295 with questions or to obtain prior authorization for services.
### Applied Behavior Analysis

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
<th>Units of service</th>
<th>Available by telehealth?</th>
<th>Provider Type</th>
<th>Authorization required?</th>
<th>Criteria</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0031</td>
<td>Initial functional assessment</td>
<td>Event</td>
<td>No</td>
<td>BCBA, BCBA-D, BCaBA</td>
<td>Yes</td>
<td>BMS</td>
<td>F to F, 1:1, Max one per year, may be billed in conjunction with other ABA codes</td>
</tr>
<tr>
<td>H0032</td>
<td>Development of ABA plan</td>
<td>15 min</td>
<td>No</td>
<td>BCBA, BCBA-D, BCaBA</td>
<td>Yes</td>
<td>BMS</td>
<td>F to F, 1:1, Can be billed in conjunction with others up to 40 hours per week and/or 8 hours within a 24-hour period</td>
</tr>
<tr>
<td>H2012</td>
<td>Behavioral Health Day Tx</td>
<td>60 min</td>
<td>No</td>
<td>BCBA or BCBA-D</td>
<td>Yes</td>
<td>BMS</td>
<td>F to F, 1:1, Can be billed in conjunction with others up to 40 hours per week and/or 8 hours within a 24-hour period</td>
</tr>
<tr>
<td>H2019</td>
<td>Therapeutic Behavioral Services</td>
<td>15 min</td>
<td>No</td>
<td>BCaBA</td>
<td>Yes</td>
<td>BMS</td>
<td>F to F, 1:1, Can be billed in conjunction with others up to 40 hours per week and/or 8 hours within a 24-hour period</td>
</tr>
<tr>
<td>H2014</td>
<td>Group Skills Training and Dev.</td>
<td>15 min</td>
<td>No</td>
<td>BCBA, BCBA-D, BCaBA</td>
<td>Yes</td>
<td>BMS</td>
<td>F to F, 1:2 to 3, Can be billed in conjunction with others up to 40 hours per week, and/or 8 hours within a 24-hour period</td>
</tr>
<tr>
<td>H2014U4</td>
<td>Individual Skills Training and Dev.</td>
<td>15 min</td>
<td>No</td>
<td>RBT under supervision, BCBA, BCBA-D, BCaBA</td>
<td>Yes</td>
<td>BMS</td>
<td>F to F, 1:1, Can be billed in conjunction with others up to 40 hours per week and/or 8 hours within a 24-hour period</td>
</tr>
<tr>
<td>H2014U5</td>
<td>Individual Skills Training and Dev.</td>
<td>15 min</td>
<td>No</td>
<td>RBT under supervision, BCBA, BCBA-D, BCaBA</td>
<td>Yes</td>
<td>BMS</td>
<td>F to F, 1:1, Can be billed in conjunction with others up to 40 hours per week and/or 8 hours within a 24-hour period</td>
</tr>
</tbody>
</table>

All ABA services must comply with the BMS provider manual chapter 519.23

*** Non par providers must submit authorization request for all services.
## ECT and TMS

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>90870</td>
<td>Electroconvulsive therapy</td>
<td>Episode</td>
<td>No</td>
<td>Yes</td>
<td>Interqual</td>
</tr>
<tr>
<td>90867</td>
<td>Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management</td>
<td>Episode</td>
<td>No</td>
<td>Yes</td>
<td>Interqual</td>
</tr>
<tr>
<td>90868</td>
<td>Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management</td>
<td>Episode</td>
<td>No</td>
<td>Yes</td>
<td>Interqual</td>
</tr>
<tr>
<td>90869</td>
<td>Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; Subsequent motor threshold re-determination with delivery and management</td>
<td>Episode</td>
<td>No</td>
<td>Yes</td>
<td>Interqual</td>
</tr>
</tbody>
</table>

## FQHC-RHC

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
<th>Units of service</th>
<th>Available by telehealth?</th>
<th>Authorizations required?</th>
<th>Provider type</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1015</td>
<td>Behavioral Health Encounter</td>
<td>Per encounter</td>
<td>Yes (see BMS manual)</td>
<td>No</td>
<td>Limit one BH encounter per day. Physician, physician extender, licensed psychologist, LICSW, LCSW, LGSW and LPC</td>
<td>Encounter code must be accompanied by procedure code representing activity conducted, may not be used for group therapy</td>
</tr>
<tr>
<td>90853</td>
<td>Group Psychotherapy</td>
<td>Per group</td>
<td>Yes (see BMS manual)</td>
<td>No</td>
<td>Physician, licensed psychologist, LICSW, LCSW, LGSW and LPC</td>
<td>Maximum 12 per group, must be billed outside encounter code, cannot be billed in combination with another BH service provided on same day under encounter code.</td>
</tr>
</tbody>
</table>

*** Non par providers must submit authorization request for all services.
### Inpatient and PRTF

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
<th>Units of service</th>
<th>Available by telehealth?</th>
<th>Provider type</th>
<th>Authorization required?</th>
<th>Criteria</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Acute Inpatient Care (Mental Health or SUD diagnoses)</td>
<td>Per diem</td>
<td>No</td>
<td>Hospital or IMD</td>
<td>Yes</td>
<td>Interqual</td>
<td>Must be authorized within one working day of admission, contracted rate</td>
</tr>
<tr>
<td></td>
<td>Psychiatric Residential Treatment for individuals under 21</td>
<td>Per diem</td>
<td>No</td>
<td>Approved unit</td>
<td>Yes</td>
<td>BMS</td>
<td>Must be authorized within one working day of admission, contracted rate, facility must comply with BMS requirements at Chapter 531</td>
</tr>
</tbody>
</table>

***** The following are not billable services for WV Medicaid:
- Observation for behavioral health diagnosis
- Residential services (group home, etc.)
- Bundled Medication Assisted Treatment
- Subacute level of psychiatric hospitalization

*** Non par providers must submit authorization request for all services.

### Partial Hospitalization

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>H0015*</td>
<td>Treatment session</td>
<td>Hour</td>
<td>Yes</td>
<td>Yes after 30 sessions</td>
<td>Interqual</td>
<td>Maximum 3 hours, may not be billed with 90853 or H0035</td>
</tr>
<tr>
<td>H0035*</td>
<td>Per diem treatment</td>
<td>Session</td>
<td>Yes</td>
<td>Yes after 30 sessions</td>
<td>Interqual</td>
<td>Minimum four hours, may not be billed with 90853 or H0015</td>
</tr>
<tr>
<td>90853*</td>
<td>Intensive group therapy</td>
<td>Two hours</td>
<td>Yes</td>
<td>Yes after 30 sessions</td>
<td>Interqual</td>
<td>Two-hour sessions, may not be billed with H0015 or H0035</td>
</tr>
</tbody>
</table>

* Must be billed on UB
** PHP must be certified by BMS
***Medical services may not be billed outside the PHP bundle
Refer to BMS’ provider manual chapter 510.5
### Urine Screens

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>80305-80307</td>
<td>Presumptive drug screens</td>
<td>Event</td>
<td>No</td>
<td>Yes after 24 per calendar year</td>
<td>BMS</td>
<td>Review BMS policy at Chapter 529.2, one permitted per date of service</td>
</tr>
<tr>
<td>G0431, G0434</td>
<td>Definitive drug screens</td>
<td>Event</td>
<td>No</td>
<td>Yes after 12 per calendar year</td>
<td>BMS</td>
<td>Review BMS policy at Chapter 529.2, one permitted per date of service</td>
</tr>
</tbody>
</table>

*** Non par providers must submit authorization request for all services  
****Breathalyzer may not be billed in combination with any urine drug code other than 80305

### Psychological Testing

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>96112</td>
<td>Developmental test administration by qualified professional with interpretation and report</td>
<td>First hour</td>
<td>No</td>
<td>No</td>
<td>Interqual</td>
<td>May only be billed one per event, may only be performed once per year per provider</td>
</tr>
<tr>
<td>96113</td>
<td>Developmental test administration by qualified professional with interpretation and report</td>
<td>Each additional 30 minutes</td>
<td>No</td>
<td>Yes after 6 Units</td>
<td>Interqual</td>
<td>Billed in conjunction with 96112, may not be billed in conjunction with any other psychological testing code other than 96130 and 96131, once per year per provider</td>
</tr>
<tr>
<td>96130</td>
<td>Psychological testing evaluation services by qualified health care professional, including interpretation, report preparation and feedback to patient and caregivers</td>
<td>First hour</td>
<td>No</td>
<td>No</td>
<td>Interqual</td>
<td>May be billed in conjunction with other psychological testing codes, maximum one unit, may only be billed once per year per provider</td>
</tr>
</tbody>
</table>
### Psychological Testing, continued

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>96131</td>
<td>Psychological testing evaluation services by qualified health care professional, including interpretation, report preparation and feedback to patient and caregivers</td>
<td>Each subsequent hour</td>
<td>No</td>
<td>Yes, after one unit</td>
<td>Interqual</td>
<td>May be billed in conjunction with other psychological testing codes, may only be billed once per year per provider</td>
</tr>
<tr>
<td>96132</td>
<td>Neuropsychological testing evaluation services by qualified health care professional, including interpretation, report prep, feedback to patient and caregivers</td>
<td>First hour</td>
<td>No</td>
<td>Yes</td>
<td>Interqual</td>
<td>May be billed in conjunction with 96136 and 96137 once per year per provider, maximum one event</td>
</tr>
<tr>
<td>96133</td>
<td>Neuropsychological testing evaluation services by qualified health care professional, including interpretation, report prep, feedback to patient and caregivers</td>
<td>Each additional hour</td>
<td>No</td>
<td>Yes</td>
<td>Interqual</td>
<td>May be billed in conjunction with 96132, 96136, 96137 once per year per provider</td>
</tr>
<tr>
<td>96136</td>
<td>Psychological or neuropsychological test administration and scoring by qualified health care professional, two or more tests, any method</td>
<td>First 30 minutes</td>
<td>No</td>
<td>No</td>
<td>Interqual</td>
<td>May be billed only once per event, may not be used for administration of screening tools, may be billed in conjunction with any other testing code other than 96112 and 96113 once per year per provider, maximum one event</td>
</tr>
</tbody>
</table>
### Psychological Testing, continued

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>96137</td>
<td>Psychological or neuropsychological test administration and scoring by qualified health care professional, two or more tests, any method</td>
<td>Each additional 30 minutes</td>
<td>No</td>
<td>Yes, after 6 units</td>
<td>Interqual</td>
<td>Billed in conjunction with 96136, may be billed in conjunction with any other psychological testing code except 96112 and 96113, may not be used for administration of screening tools, once per year per provider</td>
</tr>
<tr>
<td>96146</td>
<td>Psychological or neuropsychological test administration, with single automated instrument via electronic platform, with automated result only</td>
<td>Event</td>
<td>No</td>
<td>No</td>
<td>Interqual</td>
<td>May be billed in conjunction with other psychological testing codes</td>
</tr>
<tr>
<td>96116</td>
<td>Neurobehavioral status exam, administration, face to face time with patient and time interpreting test results and preparing report</td>
<td>Event</td>
<td>No</td>
<td>No</td>
<td>Interqual</td>
<td>One per six months per provider, must be performed by qualified professional</td>
</tr>
</tbody>
</table>

*** Grid is THP policy until development of BMS manual and standards. Non par providers must obtain prior authorization for all events.  
*** Non par providers must submit authorization request for all services
<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
<th>Units of service</th>
<th>Available by Telehealth (must use POS 02)</th>
<th>Requires Prior Authorization</th>
<th>Criteria</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0031</td>
<td>Mental Health Assessment by Non-Physician</td>
<td>Event</td>
<td>Yes</td>
<td>No</td>
<td>BMS</td>
<td></td>
</tr>
<tr>
<td>90791</td>
<td>Psychiatric Diagnostic Evaluation</td>
<td>Event</td>
<td>Yes</td>
<td>No</td>
<td>BMS</td>
<td></td>
</tr>
<tr>
<td>90792</td>
<td>Psychiatric Diagnostic Evaluation w/ med serv</td>
<td>Event</td>
<td>Yes</td>
<td>No</td>
<td>BMS</td>
<td></td>
</tr>
<tr>
<td>T1023 HE</td>
<td>Screening by Licensed Psychologist</td>
<td>Event</td>
<td>Yes</td>
<td>No</td>
<td>BMS</td>
<td></td>
</tr>
<tr>
<td>H0032</td>
<td>Mental Health Service Plan Development</td>
<td>15 min</td>
<td>Yes</td>
<td>No</td>
<td>BMS</td>
<td></td>
</tr>
<tr>
<td>H0032 AH</td>
<td>Mental Health Service Plan Development by Psychologist</td>
<td>15 min</td>
<td>Yes</td>
<td>No</td>
<td>BMS</td>
<td></td>
</tr>
<tr>
<td>G9008</td>
<td>Physician Coordinated Care Oversight Services</td>
<td>15 min</td>
<td>Yes</td>
<td>No</td>
<td>BMS</td>
<td></td>
</tr>
<tr>
<td>90887</td>
<td>Case Consultation</td>
<td>Event</td>
<td>Yes</td>
<td>No</td>
<td>BMS</td>
<td>One unit per 90 days</td>
</tr>
<tr>
<td>H0004 HO</td>
<td>BH Counseling, Professional, Individual</td>
<td>15 min</td>
<td>Yes</td>
<td>No</td>
<td>BMS</td>
<td></td>
</tr>
<tr>
<td>H0004 HO HQ</td>
<td>BH Counseling, Professional, Grp</td>
<td>15 min</td>
<td>Yes</td>
<td>No</td>
<td>BMS</td>
<td></td>
</tr>
<tr>
<td>H0004</td>
<td>BH Counseling, Supportive, Ind.</td>
<td>15 min</td>
<td>Yes</td>
<td>No</td>
<td>BMS</td>
<td></td>
</tr>
<tr>
<td>H0004 HQ</td>
<td>BH Counseling, Supportive, Grp.</td>
<td>15 min</td>
<td>Yes</td>
<td>No</td>
<td>BMS</td>
<td></td>
</tr>
<tr>
<td>H0038</td>
<td>Peer recovery support</td>
<td>15 min</td>
<td>Yes</td>
<td>Yes after 400 units</td>
<td>BMS</td>
<td>Peer must be certified by BMS, max case load of 20</td>
</tr>
<tr>
<td>T1017</td>
<td>Targeted Case Management</td>
<td>15 min</td>
<td>Yes, excluding required F to F monthly contact</td>
<td>No</td>
<td>BMS</td>
<td>Service must conform to requirements in BMS manual</td>
</tr>
</tbody>
</table>
## LBHC, continued

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
<th>Units of service</th>
<th>Available by Telehealth (must use POS 02)</th>
<th>Requires Prior Authorization</th>
<th>Criteria</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>90846</td>
<td>Family Psychotherapy w/o Patient present</td>
<td>Event</td>
<td>Yes</td>
<td>No</td>
<td>BMS</td>
<td></td>
</tr>
<tr>
<td>90847</td>
<td>Family Psychotherapy w Patient present</td>
<td>Event</td>
<td>Yes</td>
<td>No</td>
<td>BMS</td>
<td></td>
</tr>
<tr>
<td>90853</td>
<td>Group Psychotherapy</td>
<td>Per hour</td>
<td>No</td>
<td>No</td>
<td>BMS</td>
<td></td>
</tr>
<tr>
<td>90832</td>
<td>Psychotherapy 30 min</td>
<td></td>
<td>Yes</td>
<td>No</td>
<td>BMS</td>
<td></td>
</tr>
<tr>
<td>90834</td>
<td>Psychotherapy 45 min</td>
<td></td>
<td>Yes</td>
<td>No</td>
<td>BMS</td>
<td></td>
</tr>
<tr>
<td>90837</td>
<td>Psychotherapy 60 min</td>
<td></td>
<td>Yes</td>
<td>No</td>
<td>BMS</td>
<td></td>
</tr>
<tr>
<td>90839</td>
<td>Psychotherapy for Crisis 60 min</td>
<td></td>
<td>Yes</td>
<td>No</td>
<td>BMS</td>
<td></td>
</tr>
<tr>
<td>90840</td>
<td>Psychotherapy for Crisis each additional 30 min</td>
<td>30 min</td>
<td>Yes</td>
<td>No</td>
<td>BMS</td>
<td></td>
</tr>
</tbody>
</table>

### IOP Services (Programs must be approved by BMS in advance and providers must bill with IS modifier unless daily rate)

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
<th>Units of service</th>
<th>Available by Telehealth (must use POS 02)</th>
<th>Requires Prior Authorization</th>
<th>Criteria</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0004</td>
<td>BH Counseling, Professional, Ind., Intensive Service</td>
<td>15 min</td>
<td>Yes</td>
<td>Yes after 30 total IOP dates of service</td>
<td>BMS</td>
<td>Program must be certified by BMS</td>
</tr>
<tr>
<td>H0004</td>
<td>BH Counseling, Professional, Grp., Intensive Service</td>
<td>15 min</td>
<td>Yes</td>
<td>Yes after 30 total IOP dates of service</td>
<td>BMS</td>
<td>Program must be certified by BMS</td>
</tr>
<tr>
<td>H0004</td>
<td>BH Counseling, Supportive, Ind., Intensive</td>
<td>15 min</td>
<td>Yes</td>
<td>Yes after 30 total IOP dates of service</td>
<td>BMS</td>
<td>Program must be certified by BMS</td>
</tr>
<tr>
<td>H0004</td>
<td>BH Counseling, Supportive, Grp., Intensive</td>
<td>15 min</td>
<td>Yes</td>
<td>Yes after 30 total IOP dates of service</td>
<td>BMS</td>
<td>Program must be certified by BMS</td>
</tr>
<tr>
<td>H0015</td>
<td>Bundled daily rate for IOP</td>
<td>Daily</td>
<td>Yes</td>
<td>Yes after 30 sessions/dates of service</td>
<td>BMS</td>
<td>Program must be certified by BMS</td>
</tr>
</tbody>
</table>
### Skills Training and Development

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
<th>Units of service</th>
<th>Available by Telehealth (must use POS 02)</th>
<th>Requires Prior Authorization</th>
<th>Criteria</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>H2014 U4</td>
<td>Skills Training 1:1 Paraprofessional</td>
<td>15 min</td>
<td>No</td>
<td>No</td>
<td>BMS</td>
<td></td>
</tr>
<tr>
<td>H2014 U1</td>
<td>Skills Training 1:2 to 4, Paraprofessional</td>
<td>15 min</td>
<td>No</td>
<td>No</td>
<td>BMS</td>
<td></td>
</tr>
<tr>
<td>H2014 HN U4</td>
<td>Skills Training 1:1 by Professional</td>
<td>15 min</td>
<td>No</td>
<td>No</td>
<td>BMS</td>
<td></td>
</tr>
<tr>
<td>H2014 HN U1</td>
<td>Skills Training 1:2 to 4, Professional</td>
<td>15 min</td>
<td>No</td>
<td>No</td>
<td>BMS</td>
<td></td>
</tr>
</tbody>
</table>

### Medication Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
<th>Units of service</th>
<th>Available by Telehealth (must use POS 02)</th>
<th>Requires Prior Authorization</th>
<th>Criteria</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>H2010</td>
<td>Comprehensive Medication Services (clozaril, etc.) MH</td>
<td>15 min</td>
<td>Yes</td>
<td>No</td>
<td>BMS</td>
<td>Cannot be used for MAT</td>
</tr>
</tbody>
</table>

### Comprehensive Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
<th>Units of service</th>
<th>Available by Telehealth (must use POS 02)</th>
<th>Requires Prior Authorization</th>
<th>Criteria</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>H2012</td>
<td>Day Treatment</td>
<td>60 min</td>
<td>No</td>
<td>No</td>
<td>BMS</td>
<td>Program must be certified by BMS</td>
</tr>
<tr>
<td>H2015U1</td>
<td>Comprehensive Community Support Services (1:12 ratio)</td>
<td>15 min</td>
<td>No</td>
<td>No</td>
<td>BMS</td>
<td>Program must be certified by BMS, may be bundled to daily rate with permission</td>
</tr>
<tr>
<td>H2015U2</td>
<td>Comprehensive Community Support Services (1:8 ratio)</td>
<td>15 min</td>
<td>No</td>
<td>No</td>
<td>BMS</td>
<td>Program must be certified by BMS, may be bundled to daily rate with permission</td>
</tr>
<tr>
<td>H2011</td>
<td>Crisis Intervention</td>
<td>15 min</td>
<td>No</td>
<td>No</td>
<td>BMS</td>
<td>maximum allowable 16 units per 30 days</td>
</tr>
<tr>
<td>H0036</td>
<td>Community Psychiatric Supportive Treatment (CSU)</td>
<td>15 min</td>
<td>No</td>
<td>Yes after 144 units</td>
<td>BMS</td>
<td>CSU must be certified by BMS, maximum 48 units per day, max total 288 units per six months per BMS manual, telephone IDT may be required after extended stay</td>
</tr>
<tr>
<td>Code</td>
<td>Descriptor</td>
<td>Units of service</td>
<td>Available by Telehealth (must use POS 02)</td>
<td>Requires Prior Authorization</td>
<td>Criteria</td>
<td>Notes</td>
</tr>
<tr>
<td>--------</td>
<td>-------------------------------------------</td>
<td>------------------</td>
<td>------------------------------------------</td>
<td>------------------------------</td>
<td>----------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Comprehensive Services, Cont.</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H0040</td>
<td>Assertive Community Treatment (ACT)</td>
<td>Daily rate</td>
<td>Yes partial</td>
<td>Yes</td>
<td>BMS</td>
<td>Team must be certified in advance by BMS and comply with BMS manual requirements in Chapter 503</td>
</tr>
<tr>
<td><strong>Behavior Management Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H2019</td>
<td>Therapeutic Behavioral Services, Development</td>
<td>No</td>
<td>No</td>
<td>BMS</td>
<td></td>
<td>Not to be used for autism, see ABA section</td>
</tr>
<tr>
<td>H2019</td>
<td>Therapeutic Behavioral Services, Implementation</td>
<td>No</td>
<td>No</td>
<td>BMS</td>
<td></td>
<td>Not to be used for autism, see ABA section</td>
</tr>
<tr>
<td><strong>Transportation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A0120</td>
<td>Transportation by Minibus</td>
<td>Max 6 trips daily</td>
<td>No</td>
<td>BMS</td>
<td></td>
<td>Transportation must meet BMS stipulations for programming and mileage limitations, only paid in ACT and CCSS programs</td>
</tr>
<tr>
<td>A0160</td>
<td>Transportation by mile</td>
<td>One mile</td>
<td>No</td>
<td>BMS</td>
<td></td>
<td>Transportation must meet BMS stipulations for programming and mileage limitations, only paid in ACT and CCSS programs</td>
</tr>
<tr>
<td><strong>Telehealth</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q3014GT</td>
<td>Telehealth origination fee</td>
<td>Event</td>
<td>No</td>
<td>BMS</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### LBHC, continued

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
<th>Units of service</th>
<th>Available by Telehealth (must use POS 02)</th>
<th>Requires Prior Authorization</th>
<th>Criteria</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>H2036U1 HF</td>
<td>Residential Recovery Services ASAM Level 3.1</td>
<td>Daily rate</td>
<td>No</td>
<td>Yes after 3 days</td>
<td>BMS</td>
<td>Program must be certified by BMS</td>
</tr>
<tr>
<td>H2036U3 HF</td>
<td>Residential Recovery Services ASAM Level 3.3</td>
<td>Daily rate</td>
<td>No</td>
<td>Yes after 3 days</td>
<td>BMS</td>
<td>Program must be certified by BMS</td>
</tr>
<tr>
<td>H2036U5 HF</td>
<td>Residential Recovery Services ASAM Level 3.5</td>
<td>Daily rate</td>
<td>No</td>
<td>Yes after 3 days</td>
<td>BMS</td>
<td>Program must be certified by BMS</td>
</tr>
<tr>
<td>H2036U7 HF</td>
<td>Residential Recovery Services ASAM Level 3.7</td>
<td>Daily rate</td>
<td>No</td>
<td>Yes after 3 days</td>
<td>BMS</td>
<td>Program must be certified by BMS, may be hospital based</td>
</tr>
</tbody>
</table>

### E/M Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Event Type</th>
<th>Requires Prior Authorization</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>99205</td>
<td>New Patient</td>
<td>Event</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>99211</td>
<td>Est. Patient Simple</td>
<td>Event</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>99212</td>
<td>Est. Patient Problem Focused</td>
<td>Event</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>99213</td>
<td>Est. Patient Expanded</td>
<td>Event</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>99214</td>
<td>Est. Patient Moderate</td>
<td>Event</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>99215</td>
<td>Est. Patient High Complexity</td>
<td>Event</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>96372</td>
<td>Injection</td>
<td>Event</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>90833</td>
<td>Therapy add on 30 minutes</td>
<td>Event</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>90836</td>
<td>Therapy add on 45 minutes</td>
<td>Event</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

*** All telehealth services require POS 02
*** Non par providers must submit authorization request for all services.
**** In Home services are permitted for many codes with a POS 12. Please see BMS manual chapter 503 for further clarification.
### Professional Services

Chapter 521, Behavioral Health Outpatient Services (group or individual):
- Physician
- Physician Extender
- Licensed Psychologist (LP)
- Supervised Psychologist (SP)
- Licensed Independent Clinical Social Worker (LICSW)
- Licensed Professional Counselor (LPC)
- Licensed Clinical Social Worker (LCSW); and
- Licensed Graduate Social Worker (LGSW).

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
<th>Units of service</th>
<th>Available by Telehealth?</th>
<th>Requires Prior Authorization</th>
<th>Criteria</th>
<th>Notes***</th>
</tr>
</thead>
<tbody>
<tr>
<td>90791</td>
<td>Psychiatric Diagnostic Evaluation</td>
<td>Event</td>
<td>Yes</td>
<td>No</td>
<td>BMS</td>
<td>Max. two Events per year by same provider/entity, must be performed by physician, physician extender, Lic Psychologist, Supervised Psychologist, LICSW or LPC</td>
</tr>
<tr>
<td>90792</td>
<td>Psychiatric Diagnostic Evaluation w/ med serv</td>
<td>Event</td>
<td>Yes</td>
<td>No</td>
<td>BMS</td>
<td>Max two Events per year by same provider/entity, must be performed by physician or physician extender</td>
</tr>
<tr>
<td>H0031</td>
<td>Mental Health Assessment by Non-Physician</td>
<td>Event</td>
<td>Yes</td>
<td>No</td>
<td>BMS</td>
<td>Max two per year, provided by licensed Psychologist, Supervised Psychologist who is supervised by a Board approved Supervisor, LICSW, LCSW, LGSW, or LPC</td>
</tr>
<tr>
<td>90832</td>
<td>Individual Psychotherapy 16 to 37 min.</td>
<td>16 to 37 min.</td>
<td>Yes</td>
<td>No</td>
<td>BMS</td>
<td>Physician, physician extender, and independently enrolled Lic. Psychologist, Supervised Psychologist, LICSW, LPC, LCSW, LGSW</td>
</tr>
<tr>
<td>90832</td>
<td>Individual Psychotherapy 16 to 37 min.</td>
<td>16 to 37 min.</td>
<td>Yes</td>
<td>No</td>
<td>BMS</td>
<td>Non-independently enrolled Lic. Psychologist, Supervised Psychologist, LICSW, LPC, LCSW, LGSW</td>
</tr>
<tr>
<td>90833</td>
<td>Individual Psychotherapy as add on to E/M codes</td>
<td>16 to 37 min.</td>
<td>Yes</td>
<td>No</td>
<td>BMS</td>
<td>May be performed by physician or physician extender only</td>
</tr>
<tr>
<td>90834</td>
<td>Individual Psychotherapy 38 to 52 min.</td>
<td>38 to 52 min.</td>
<td>Yes</td>
<td>No</td>
<td>BMS</td>
<td>Physician, physician extender, and independently enrolled Lic. Psychologist, Supervised Psychologist, LICSW, LPC, LCSW, LGSW</td>
</tr>
<tr>
<td>Code</td>
<td>Descriptor</td>
<td>Units of service</td>
<td>Available by Telehealth? ***</td>
<td>Requires Prior Authorization</td>
<td>Criteria</td>
<td>Notes***</td>
</tr>
<tr>
<td>--------</td>
<td>----------------------------------------------</td>
<td>------------------</td>
<td>-------------------------------</td>
<td>------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------</td>
</tr>
<tr>
<td>90834</td>
<td>Individual Psychotherapy</td>
<td>38 to 52 min.</td>
<td>Yes</td>
<td>No</td>
<td>BMS</td>
<td>Non-independently enrolled Lic. Psychologist, Supervised Psychologist, LICSW, LPC, LCSW, LGSW</td>
</tr>
<tr>
<td>90836</td>
<td>Individual Psychotherapy as add on to E/M codes</td>
<td>38 to 52 min.</td>
<td>Yes</td>
<td>No</td>
<td>BMS</td>
<td>May be performed by physician or physician extender only</td>
</tr>
<tr>
<td>90837</td>
<td>Individual Psychotherapy</td>
<td>53 plus min.</td>
<td>Yes</td>
<td>No</td>
<td>BMS</td>
<td>Physician, physician extender, and independently enrolled Lic. Psychologist, Supv. Psychologist, LICSW, LPC</td>
</tr>
<tr>
<td>90837</td>
<td>Individual Psychotherapy</td>
<td>53 plus min.</td>
<td>Yes</td>
<td>No</td>
<td>BMS</td>
<td>Non independently enrolled Lic. Psychologist, Supv. Psychologist, LICSW and LPC</td>
</tr>
<tr>
<td>90875</td>
<td>Individual Psychotherapy with Biofeedback</td>
<td>30 min.</td>
<td>No</td>
<td>No</td>
<td>BMS</td>
<td>Physician or Physician extender only</td>
</tr>
<tr>
<td>90876</td>
<td>Individual Psychotherapy with Biofeedback</td>
<td>45 min.</td>
<td>No</td>
<td>No</td>
<td>BMS</td>
<td>Physician or Physician extender only</td>
</tr>
<tr>
<td>90853</td>
<td>Group Psychotherapy</td>
<td>Event</td>
<td>Yes</td>
<td>No</td>
<td>BMS</td>
<td>Physician, physician extender, and independently enrolled Lic. Psychologist, Supervised Psychologist, LICSW, LPC, LCSW, LGSW. Max 12 per group</td>
</tr>
<tr>
<td>90853</td>
<td>Group Psychotherapy</td>
<td>Event</td>
<td>Yes</td>
<td>No</td>
<td>BMS</td>
<td>Non-independently enrolled Lic. Psychologist, Supervised Psychologist, LICSW, LPC, LCSW, LGSW. Max 12 per group</td>
</tr>
<tr>
<td>90839</td>
<td>Psychotherapy for Crisis</td>
<td>60 min.</td>
<td>No</td>
<td>No</td>
<td>BMS</td>
<td>Physician, physician extender, Lic. Psychologist, Supv. Psychologist, LICSW, LPC only</td>
</tr>
<tr>
<td>90840</td>
<td>Psychotherapy for Crisis each additional 30 minutes</td>
<td>30 min.</td>
<td>No</td>
<td>No</td>
<td>BMS</td>
<td>Physician, physician extender, Lic. Psychologist, Supv. Psychologist, LICSW, LPC only</td>
</tr>
<tr>
<td>90846</td>
<td>Family Psychotherapy without Patient</td>
<td>45 to 50 min.</td>
<td>Yes</td>
<td>No</td>
<td>BMS</td>
<td>Physician, physician extender, Lic. Psychologist, Supv. Psychologist, LICSW, LPC only</td>
</tr>
</tbody>
</table>
### Professional Services, continued

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
<th>Units of service</th>
<th>Available by Telehealth? ***</th>
<th>Requires Prior Authorization</th>
<th>Criteria</th>
<th>Notes***</th>
</tr>
</thead>
<tbody>
<tr>
<td>90847</td>
<td>Family Psychotherapy with Patient</td>
<td>45 to 50 min.</td>
<td>Yes</td>
<td>No</td>
<td>BMS</td>
<td>Physician, physician extender, and independently enrolled Lic. Psychologist, Supv. Psychologist, LICSW, LPC only</td>
</tr>
<tr>
<td>90847 AJ</td>
<td>Family Psychotherapy with Patient</td>
<td>45 to 50 min.</td>
<td>Yes</td>
<td>No</td>
<td>BMS</td>
<td>Non-independently enrolled Lic. Psychologist, Supervised Psychologist, LICSW, LPC, LCSW, LGSW</td>
</tr>
<tr>
<td>Q3014 GT</td>
<td>Telehealth origination fee</td>
<td>Event</td>
<td>No</td>
<td>BMS</td>
<td>Only one entity may bill in an encounter</td>
<td></td>
</tr>
</tbody>
</table>

### Evaluation And Management Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
<th>Units of service</th>
<th>Available by Telehealth? ***</th>
<th>Requires Prior Authorization</th>
<th>Criteria</th>
<th>Notes***</th>
</tr>
</thead>
<tbody>
<tr>
<td>99205</td>
<td>New Patient</td>
<td>Event</td>
<td>Yes</td>
<td>No</td>
<td>Physician, physician extender</td>
<td></td>
</tr>
<tr>
<td>99211</td>
<td>Est. Patient Simple</td>
<td>Event</td>
<td>Yes</td>
<td>No</td>
<td>Physician, physician extender</td>
<td></td>
</tr>
<tr>
<td>99212</td>
<td>Est. Patient Problem Focused</td>
<td>Event</td>
<td>Yes</td>
<td>No</td>
<td>Physician, physician extender</td>
<td></td>
</tr>
<tr>
<td>99213</td>
<td>Est. Patient Expanded</td>
<td>Event</td>
<td>Yes</td>
<td>No</td>
<td>Physician, physician extender</td>
<td></td>
</tr>
<tr>
<td>99214</td>
<td>Est. Patient Moderate</td>
<td>Event</td>
<td>Yes</td>
<td>No</td>
<td>Physician, physician extender</td>
<td></td>
</tr>
<tr>
<td>99215</td>
<td>Est. Patient High Complexity</td>
<td>Event</td>
<td>Yes</td>
<td>No</td>
<td>Physician, physician extender</td>
<td></td>
</tr>
<tr>
<td>96372</td>
<td>Injection</td>
<td>Event</td>
<td>No</td>
<td>No</td>
<td>Physician, physician extender</td>
<td></td>
</tr>
<tr>
<td>90833</td>
<td>Therapy add on 30 minutes</td>
<td>Event</td>
<td>Yes</td>
<td>No</td>
<td>Physician, physician extender</td>
<td></td>
</tr>
<tr>
<td>90836</td>
<td>Therapy add on 45 minutes</td>
<td>Event</td>
<td>Yes</td>
<td>No</td>
<td>Physician, physician extender</td>
<td></td>
</tr>
</tbody>
</table>

*** All telehealth services require POS 02
*** All clinicians billing in a group or physician practice must be credentialed by THP and must utilize the correct billing modifiers. Please review THP policy regarding ability to bill under physician NPI
*** Non par providers must submit authorization request for all services.
*** Please refer to BMS manual and THP policy for credentialing exceptions made in OBMAT programs
Medicaid Behavioral Health Credentialing and Billing Guidelines

The Health Plan requires credentialing of all licensed behavioral health practitioners operating within a physician’s practice.

Unlicensed personnel may not bill for behavioral health services within a physician’s practice with the exception of supervised psychologists officially approved by the WV Board of Examiners of Psychology. THP will only reimburse supervised psychologists when providing services to our Medicaid members. A supervised psychologist must appear on the web page of the Board of Examiners of Psychologists in WV found [here](#).

Please note that this guideline does not apply to physician’s offices within Licensed Behavioral Health Centers. Although the billing procedures described below do not apply to FQHC/RHC, the requirement for credentialing does apply to these agencies.

Also note that The Health Plan, in conformity with Mental Health Parity rules, does not require pre-authorization for clinic-based behavioral health outpatient services. Our authorization list is available on our [corporate website](#) in the “For Providers” section.

The Health Plan defaults to CMS policy as interpreted for Medicare for our Commercial plans unless the plan description specifies otherwise. If there is a question regarding this, please contact THP’s Customer Service Department at 1.800.624.6961.

**Medicaid**

Chapter 519.2 and Chapter 521 of the Bureau for Medical Services (BMS) provider manuals clearly describe the circumstances under which a licensed behavioral health practitioner may provide services under the auspices of a physician’s practice (again, these rules do not apply to physicians or practitioners employed by a licensed behavioral health center or an FQHC/RHC). The chapters are available on the WV DHHR’s [website](#). For the purpose of this section only, physician is understood to include physician extenders such as APRN and PA.

Note that there is an exception, described below, for Office Based Medication Assisted Treatment programs properly certified/registered with the Office of Health Facility Licensure and Certification. This exception will be detailed below and applies only to members with Medicaid coverage/benefits.

Physicians may have appropriately licensed behavioral health staff working under them to provide behavioral health services which include the following: Licensed Professional Counselor (LPC), Licensed Independent Clinical Social Worker (LICSW), Licensed Certified Social Worker (LCSW), Licensed Graduate Social Worker (LGSW), Supervised Psychologist and Licensed Psychologist (LP).

The BMS does not specify that a licensed behavioral health practitioner must practice under the supervision of a psychiatrist, nor does it make any statement about the scope of practice of the supervising physician.
The following staff may bill for behavioral health services in a medical clinic setting:

- Licensed Psychologist
- Advanced Practice Registered Nurse
- Physician Extender
- Supervised Psychologist officially approved by the WVBOP
- LICSW
- LCSW
- LGSW
- Licensed Professional Counselor

The BMS requires that all staff with the exception of the LCSW and the LGSW bill under their own rendering NPI, using the appropriate CPT code without a modifier.

Please note OBMAT exception below. Therefore, all staff other than the LCSW and the LGSW must be credentialed with THP before they can bill for services. The LCSW and LGSW may bill under the physician’s NPI with an AJ modifier on the CPT code and do not need to be credentialed by THP. Currently, the reimbursement level for modified and non-modified CPT codes is almost identical in most cases.

**Office Based Medication Assisted Treatment (OBMAT) programs (applies to WV Medicaid only):** In those OBMAT programs that are properly certified/registered with the Office of Health Facility Licensure and Certification (OHFLAC) the following staffing requirements/permissions will apply. **These individuals may bill under the physician’s NPI using the AJ modifier so long as the appropriate supervision requirements are met:**

**Staff Credentials:** The following are the minimum supervision requirements per degree/credential type:

- **Bachelor’s Degree in Human Services without Alcohol and Drug Counselor Credential***: Indirect supervision required by Clinical Supervisor, Advanced Alcohol and Drug Counselor, Certified Clinical Counselor, Master Addiction Counselor, Licensed Psychologist, Licensed Professional Counselor, or Licensed Independent Clinical Social Worker.

- **Master’s Degree Only, includes Licensed Clinical Social Worker and Licensed Graduate Social Worker***: Indirect supervision required by Clinical Supervisor, Advanced Alcohol and Drug Counselor, Certified Clinical Counselor, Master Addiction Counselor, Licensed Psychologist, Licensed Professional Counselor, or Licensed Independent Clinical Social Worker.

- **Doctoral Level, Non-Licensed***: Indirect supervision required by Clinical Supervisor, Advanced Alcohol and Drug Counselor, Certified Clinical Counselor, Master Addiction Counselor, Licensed Psychologist, Licensed Professional Counselor, or Licensed Independent Clinical Social Worker.

The following providers do not require supervision but will require credentialing with THP and therefore must bill as rendering provider. They may not bill under the physician’s NPI:

- Licensed Independent Clinical Social Worker
- Licensed Psychologist
- Supervised Psychologist listed as such on the Board of Examiner’s website;
- Licensed Professional Counselor
- National Certified Addiction Counselor II as defined by NAADAC
- Master Addiction Counselor as defined by NAADAC
- Bachelor’s Degree in Human Services with Alcohol and Drug Counselor Credential
The WV Medicaid manual cites the following behavioral health codes as available with an AJ modifier: 90832, 90834, 90837, 90853, H0031 and 90847.

The Health Plan payment, authorization and approval methodologies conform to BMS requirements as stated in the manuals.

The Health Plan utilizes the following methodology for applications for credentialing all providers: WV Standardized Credentialing Application found on CAQH or WV Department of Insurance.

Be aware that this will require that the rendering provider have an individual National Provider Identification Number (NPI). A provider may obtain an NPI number on the NPPES website.

Should you have any questions regarding these instructions please feel free to contact our behavioral health provider engagement representative, Seth Shockey at sshockey@healthplan.org or clinical psychologist Sheila Kelly at skelly@healthplan.org.

Providers should be aware that commercial and self-insured policies may vary. Please call our customer services line at 1.877.221.9295 should there be questions regarding these types of policy coverages.

The Health Plan will conduct routine post payment reviews on billings described above. Providers suspected of improper billing may be subject to requests for prior authorization in future and/or may be reported to The Health Plan’s Special Investigations Unit for fraud, waste and abuse. New network providers may be requested to submit planned procedures for prepayment review. All out of network providers are required to submit all procedures for prior authorization.
Adult Dental

Dental Services: Adults age 21 and over

Contractual Definition: Adult coverage is limited to the treatment of fractures of mandible and maxilla, biopsy, removal of tumors, and emergency extractions. TMJ surgery and treatment are not covered for adults.

A referral from the PCP is not required for the initial evaluation by the dental provider. If extracting more than three teeth on the same date of service, the dental provider will be required to submit documentation related to the emergency extraction along with the claim.

The above requirement applies to all teeth except wisdom teeth (see exclusions).

Examples of urgent/emergent dental services are:

- Incision and drainage (I&D) of abscess
- Repair of acute wounds
- Tooth broken off to the gum line
- Non-restorable tooth
- Removal of an abscess tooth
- Removal of a tumor or treatment of a fracture; and
- Treatment of infection

Exclusions

Dental services not covered by THP include, but are not limited to, the following:

- Experimental/investigational or services for research purposes
- Removal of primary teeth whose exfoliation is imminent
- Dental services for which the prior authorization has been denied or not obtained
- Dental services for the convenience of the member, the member’s caretaker, or provider of service
- Procedure for cosmetic purposes
- Temporomandibular joint (TMJ) for adults
- Anesthesia services when solely for the convenience of the members, member’s caretaker or the provider of service
- Local anesthesia or oral sedation are considered part of the treatment procedure and may not be billed separately
- Dental services for residents of intermediate care and nursing facilities (nursing homes, ICF/MR and PRTF)
- Use of unlisted codes when a national CDT is available
- Unbundled CDT codes
- Removal of implants
- Extraction of wisdom teeth are excluded unless they meet the emergent/urgent definition.
  - Documentation is required to be submitted with the claim for all wisdom teeth extractions.
Oral surgery including dental accidents

Oral surgery is covered only for the cases below and require prior authorization.

- Oral surgery is covered for non-dental surgical and hospital procedures for birth defects (like cleft lip and cleft palate)
- Medical or surgical procedures within or next to the oral cavity or sinuses that are medically needed
- Dental services medically needed because of an accidental injury are covered when your doctor submits a plan of treatment to THP. The medical service must be performed within six months of the injury
- Medically needed medical or surgical procedures within or next to the oral cavity or sinuses resulting from the removal of tumors and cyst

Not covered oral services:

- Cosmetic services or repairs that THP decides are not needed for daily living
- Other procedures involving the teeth or areas around the teeth including, but not limited to:
  - Shortening of the mandible or maxilla for cosmetic purposes
  - Correction of malocclusion or mandibular retrognathia
  - Treatment of natural teeth due to diseases
  - Repair, removal or replacement of sound natural teeth
  - Diagnosis and treatment of temporomandibular joint (TMJ) pain dysfunction syndrome

**Procedure code 41899**

For members age 21 or older, prior authorization is required for this procedure. Please contact Customer Service. Adult dental benefits are limited to emergency extractions only.

Dental services in a hospital setting

All procedures provided by a dentist or oral surgeon in a hospital setting requires a prior authorization. Refer to the BMS website for covered codes for adult dental over the age of 21.
Children’s Dental

Children’s dental services (up to age 21) are covered by the managed care organization. Skygen USA is The Health Plan’s administrator and providers must contract with them to provide services to our members. Providers should call 1.888.983.4690. If you would like a copy of Skygen USA’s Provider Manual, please visit skygenusa.com.

Unlisted Procedure Code 41899

For members under the age of 21 that require dental services to be rendered in a hospital setting, the dental provider is required to obtain a prior authorization from Skygen USA for the procedure. Once the provider obtains the prior authorization from Skygen USA, the hospital services are required to be authorized through The Health Plan. Providers will need to contact THP’s Customer Service Department at 1.888.613.8385 to obtain the prior authorization. The authorization number from Skygen USA will be required when requesting the authorization from THP.

Oral Health Fluoride Varnish Program

Primary care providers may receive a reimbursement for fluoride varnish application.

- Fluoride varnish is reimbursable to both medical and dental providers:
  - May be billed two times/year for each type of provider = four fluoride varnish treatments/year
  - Patient must be under 21 years old
  - Code may only be billed once within a six-month period per each type of provider

- Medical Providers
  - Bill procedure code 99188
  - Apply during time of well-child visit or health screening
  - Oral health risk assessment should be conducted prior to application

- Dental Providers
  - Bill procedure code D1206
  - Provide service at a dental visit

- Topical application of fluoride (excluding fluoride varnish)
  - Bill procedure code D1208
  - CANNOT bill D1206 with D1208

Additional information regarding this program is on the BMS website.
Immunization Registry

There is a West Virginia statewide immunization information system (WVSIIIS) for all children, adolescents, and adults. WVSIIIS is a confidential, computerized information system that keeps complete and up-to-date shot records. Children often receive shots from several providers that can make the immunization record fragmented, causing missed doses or over immunization. The benefits of this registry are access to a current immunization record, better patient care, and higher immunization rates and less disease.

Childhood and adolescent immunization reviews should be done at well-child visits as well as during urgent problem-oriented visits.

For more information about this registry please call 1.877.408.8930 or visit the website at: wvimm.org/wvsiiis

Appeals and Grievances

This section outlines the information provided to Medicaid members regarding the right to file a complaint, grievance or appeal.

Complaints and Grievances

- You can file a complaint, also called a grievance, at any time.
- If you are unhappy with something that happened to you when you received health care services, you can file a complaint or grievance. Examples of why you might file a complaint or grievance include:
  - You feel you were not treated with respect
  - You are not satisfied with the health care you got
  - It took too long to get an appointment
  - You do not agree with a decision that we made
- To file a complaint or grievance you should call The Health Plan at 1.888.613.8385 (TTY:711)
- To file a complaint or grievance in writing, you may fax it to The Health Plan at 1.888.450.6025 or mail it to 1110 Main Street, Wheeling, WV 26003
- You will need to send us a letter that has:
  - Your name
  - Your mailing address
  - The reason why you are filing the complaint and what you want The Health Plan to do
  - Your doctor or authorized representative can also file a complaint or grievance for you

We will let you know when we receive your complaint or grievance. You can file a complaint or grievance at any time after the event about which you are unhappy. The Health Plan will conduct a full investigation after we receive your complaint or grievance. We will usually give you a decision within 30 calendar days and no later than 90 calendar days but may ask for extra time to give an answer.

The Health Plan will provide translation services, as needed, at no cost to you.
**Appeals**

If you believe your benefits were unfairly denied, reduced, delayed or stopped, you have the right to file an appeal with The Health Plan. You also have the right to appeal any adverse decision.

- To file an appeal, you can call The Health Plan at 1.888.613.8385.
- To file an appeal in writing, you will need to fax it to The Health Plan at 1.888.450.6025 or mail it to 1110 Main Street Wheeling, WV 26003.
- You will need to send us a letter that has:
  - Your name
  - Your provider’s name
  - The date of service
  - Your mailing address
  - The reason why we should change our decision
  - A copy of any information that you think supports your appeal, such as written comments, additional documents, records or information related to your appeal
  - Your doctor or authorized representative can also file an appeal for you

If you call and give your appeal over the phone, The Health Plan will acknowledge your appeal in a letter and send you the letter to sign. Be sure to read the letter carefully. You must sign the letter and return it to The Health Plan to have an appeal.

You must file an appeal within sixty (60) calendar days from the date on the notice of action from The Health Plan.

We will let you know when we have received your appeal and you can get copies of documents, records, and information about the appeal for free. Information may include medical necessity criteria, and any processes, strategies, or evidence-based standards used in setting coverage limits. A Committee will look at your appeal. None of the people on the Appeal Committee will have been involved in our initial decision to not authorize or pay for the health services you are appealing. If your appeal involves a medical issue, the Committee will also talk to a health care professional who has the appropriate training and experience in the field of medicine necessary for making the decision on the medical issue. We have provided the titles and qualifications of individuals who may participate in your appeal decision review.

- Medical Director – board-certified practitioners (radiology, behavioral health, obstetrics/gynecology, general surgeon with current state licensures)
- Nurse Navigators – registered nurses with current state licensures.

The Health Plan must process and provide notice to you regarding your appeal within thirty (30) calendar days.

If The Health Plan needs more information for the appeal, or if you want to provide more information, you or The Health Plan can ask for fourteen (14) more calendar days to finish the appeal. If The Health Plan decides to extend the review time to finish the appeal, you will be notified in writing within two (2) calendar days that you have the right to file a grievance if you disagree with the extension.
Fast Appeals

If your appeal is about our decision to not approve or pay for some or all of your health care services, and you need an appeal decision fast because you have not gotten the health care services and you might be badly hurt if you had to wait for a normal appeal decision, like the one described above, you can ask for a fast appeal by calling The Health Plan at 1.888.613.8385. A fast appeal must be written within (60) calendar days. If we allow a fast appeal, we will schedule a meeting with the Committee no later than forty-eight (48) hours after we get your appeal. We will call you twenty-four (24) hours after we get your appeal to let you know the date, time, and place of the meeting. We will make a decision on your appeal no later than seventy-two (72) hours after we get your appeal. If The Health Plan determines that an appeal is not a fast appeal, The Health Plan will provide your fast appeal request to the State so that they can determine a timeframe for resolution. You will get a written notice explaining the next steps in the process.

To file a fast appeal, you will need to provide us with:

- Your name
- Your provider’s name
- The date of service
- Your mailing address
- The reason why we should change our decision
- A copy of any information that you think supports your appeal, such as written comments, additional documents, records or information related to your appeal

You can file a Fast Appeal by either calling us, or mailing or faxing the information to:

The Health Plan
1110 Main Street
Wheeling, WV 26003
Phone Number: 1.888.613.8385
Fax: 1.888.450.6025

If we decide your appeal is not a fast appeal, we will handle your appeal like the normal appeals described in the section above. You have the right to file a grievance if you are unhappy with the decision to deny the fast appeal.
State Fair Hearing Process

If you are not happy with The Health Plan’s appeal decision, and your appeal is about our decision to deny, reduce, change or terminate payment for your health care services, you can request a State Fair Hearing. You can only request a State Fair Hearing if it relates to a denial of a service, a reduction in service, termination of a previously authorized service, or failure to provide service timely. You will get a notice mailed to you within thirteen (13) calendar days before any action is taken. You must request a State Fair Hearing within 120 calendar days from the notice of appeal resolution from The Health Plan. You may also request a State Fair Hearing if The Health Plan does not meet the timeframe for making a decision on your appeal.

Send your request for State Fair Hearing to:

Bureau for Medical Services
Office of Medicaid Managed Care
350 Capitol Street, Room 251
Charleston, WV 25301-3708

The Bureau for Medical Services decision will be sent to you in writing. If you are not happy with the Bureau for Medical Services decision, you can appeal to the West Virginia Insurance Commissioner by sending your appeal to:

The West Virginia Office of the Insurance Commissioner
P.O. Box 50540
Charleston, WV 25305-0540

The Health Plan will continue your benefits during the time of an appeal process or State Fair Hearing when:

• You or your provider file an appeal on a timely basis;
• The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
• The services were ordered by an authorized provider;
• The original period covered by the original authorization has not expired and;
• You request an extension of benefits within thirteen (13) days of The Health Plan determination.

To request an extension of benefits, call member service at 1.888.613.8385. The Health Plan will pay for the services in question when the result of the appeal is to overturn the original decision. The Health Plan will pay for some or all the services as determined by the final appeal decision. If the final result of your appeal is to uphold the original decision to deny, reduce, change or end payment for your services, The Health Plan may take back the money that was paid for the services while the appeal was in process, and you will be responsible for paying for the services.

Keeping Your Grievance and Appeals

The Health Plan will keep copies of your grievance and appeals documents, records and information about the grievance and appeal for your review for ten (10) years.

Provider Reconsideration (Appeal)

If a provider does not agree with the decision made by The Health Plan, they have the right to file a reconsideration. Providers are limited to one level of reconsideration/appeal. A provider has the greater of 180 days from The Health Plan’s denial or 180 days from the date of service to request a reconsideration.
MHT/WVHB Members’ Rights and Responsibilities Statement

Statement of Members’ Rights

- Receive information about The Health Plan, its services, practitioners, and your rights and responsibilities according to contract standards. We will provide this information upon enrollment, annually, and at least 30 days prior to any change. The Health Plan will provide all information according to the requirements of state law and the contract. Please see the benefit grid for covered services according to the contract.

- Be able to request and receive your medical records, and to request they be amended or corrected and receive prompt action in a timely manner of no later than 30 days from receipt of the request for records and no later than 60 days from the receipt of a request for amendments.

- Know you have the right to privacy and confidentiality with regard to your personal information. Information about your medical history and enrollment file is private. You have the right to approve or refuse the release of personal information by The Health Plan, unless the law or this agreement requires it.

- Be able to discuss appropriate or medically necessary treatment options for your condition(s) with your practitioner, even if they are not covered by The Health Plan. However, if you or your practitioners prefer a certain treatment and it is not covered by The Health Plan, you could be responsible for the cost. This information will be presented in a manner appropriate to the enrollee’s condition and ability to understand. Your appropriate behavior, such as keeping appointments, helps in this decision-making. However, this does not expand coverage by The Health Plan.

- Receive medical advice or options communicated to you without any limitations or restrictions being placed upon the practitioner or PCP by The Health Plan.

- Be treated with respect, dignity, and privacy by The Health Plan employees, practitioners, and their staff. If you feel that your treatment has not been respectful, please call The Health Plan Customer Service Department at 1.888.613.8385.

- Get prompt resolution of issues raised, including complaints or grievances and issues relating to authorization, coverage, or payment of service(s). There are informal and formal steps available to you to resolve all complaints/grievances without reprisal from The Health Plan.

- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other federal regulations on the use of restraints and seclusion.

- Change your PCP at any time by calling or writing The Health Plan. The new PCP has to be available.

- Choose a participating PCP and OB/GYN and, with proper referrals, see a participating specialist.

- Be able to refuse care from the designated practitioner and select a different affiliated practitioner.

- Know how to obtain out-of-area services.
• Help make decisions about your health care when possible and within The Health Plan guidelines as outlined in this agreement, including the right to refuse treatment.

• Make an advance directive.

• Tell us your comments, opinions or complaints about The Health Plan or your medical care.

• Have coverage denials involving medical necessity or experimental treatment reviewed, after exhaustion of The Health Plan’s internal grievance procedure, by appropriate medical professionals who are knowledgeable about the recommended or requested health care service, as part of an external review.

• Know how you can get a list of The Health Plan’s practitioner network, including the names and credentials of all participating practitioners. You should know how to choose practitioners within the Health Plan. If you have any questions regarding the qualifications of any plan physician, please contact The Health Plan’s Customer Service Department at 1.888.613.8385.

• Know you are free to exercise your rights. Exercising these rights does not adversely affect our treatment of you.

• Know how to obtain access to a summary of the Health Plan’s accreditation report.

• Health care professionals, acting within the lawful scope of practice, are not prohibited or restricted from advising or advocating on behalf of an enrollee’s health status; medical care or treatment options (including any alternative treatment that may be self-administered); any information the enrollee needs for deciding among all relevant treatment options; or the risks, benefits, and consequences of treatment or no treatment.

• Know that you will not be discriminated against in the delivery of health care services consistent with the benefits covered in your policy, based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, being homeless, sexual orientation, genetic information, or source of payment.

• Know you have full disclosure from your health care practitioner of any information relating to your medical condition or treatment plan and the ability to examine and offer corrections to your own medical records.

• Access emergency health care services, consistent with your determination of the need for such services as a prudent layperson, and post-stabilization services. No referral is needed.

• Know you can file a grievance for an administrative or medical complaint. You will continue to get good care and be treated with respect, even if you file a complaint.

• Receive continuation of benefits while your appeal is pending; however, you may have to pay for the cost of continuation of benefits if the appeal is upheld.

• Be able to have a practitioner or medical professional review any coverage denials according to The Health Plan review procedures.

• Get a second opinion from a qualified health care professional within or outside the network, at no cost to you. This second opinion could be in addition to that of a specialist referred by the PCP.

• Have all coverage denials reviewed by appropriate medical professionals consistent with The Health Plan’s review procedures.
• Be informed of plan policies and any charges for which you may be responsible.

• A woman has the right to direct access, annually, to her OB/GYN for the purpose of a well woman examination without a referral from her PCP, and no woman shall be required to obtain a referral from her PCP as a condition to coverage of prenatal or obstetrical care.

• A woman whose plan provides coverage for surgical services in an inpatient or outpatient setting has the right to reconstruction of the breast following mastectomy and reconstructive or cosmetic surgery required as a result of an injury caused by the act of a person convicted of a crime involving family violence.

• A woman whose plan provides coverage for surgical services in an inpatient or outpatient setting has the right to reconstruction of the breast following mastectomy and reconstructive or cosmetic surgery required as a result of an injury caused by the act of a person convicted of a crime involving family violence.

• A woman whose plan provides coverage for laboratory or X-ray services has a right to the following when performed for cancer screening or diagnostic purposes: (1) a baseline mammogram for women age 35 to 39, inclusive; (2) a mammogram for women age 40 to 49, inclusive, at least every two years; (3) a mammogram every year for women age 50 and over; (4) a pap smear at least annually for women age 18 and over.

• A non-symptomatic person over 50 years of age and a symptomatic person under 50 years of age have the right to colorectal cancer examinations and laboratory tests for colorectal cancer.

• Be able to have rehabilitation services.

• Receive child immunization services, which shall not be subject to payment of any deductible, per-visit charge and/or copayment.

A member with diabetes whose health benefits policy includes eye care benefits has the right to direct access to an optometrist or ophthalmologist of their choice from the panel without referral from their PCP for an annual diabetic retinal examination. When the diabetic retinal examination reveals the beginning stages of an abnormal condition, access to future examinations shall be subject to prior authorization from a PCP.

**Statement of Members’ Responsibilities**

For The Health Plan to provide appropriate and medically necessary health care services and to allow you to get the most from your plan membership, we want to work together with you and your family. Please share in responsibilities by doing the following:

• Pick a PCP. You should keep a relationship with a PCP. The PCP will be the manager and medical home for your health care needs.

• Identify yourself as a THP member to avoid mistakes when you go to the practitioner or see another practitioner.

• **Always** carry The Health Plan ID and Medicaid medical cards. **Never** let anyone else use them.

• Read this handbook. You should follow the guidelines and contact The Health Plan for help, if needed.
• Let The Health Plan know any changes in the following:
  o Name, address, telephone number.
  o Number of dependents (marriage, divorce, new baby, child leaves home, etc.).
  o Loss of ID card.
  o Change of PCP.

• Be on time for appointments. If you cannot keep an appointment, call and cancel.

• Give details about your health to the physicians. This information is needed for the diagnosis and treatment of medical problems.

• Follow directions given by your practitioners, such as what medicines to take or what foods you should eat.

• If you get emergency care outside The Health Plan service area, call The Health Plan within 48 hours.

• You must talk with your PCP or OB/GYN before receiving specialty care or services.

• You must give The Health Plan information on other insurance you have or if you have worker’s compensation or if you’re in an accident. You may have to pay The Health Plan money owed under Coordination of Benefits or Subrogation policies.

• Please be friendly to The Health Plan’s employees, practitioners and their staff.
Medicaid Members’ Rights and Responsibilities

Your Rights

As a member of The Health Plan, you have rights around your health care and to receive information according to contract standards. Each year, The Health Plan submits its annual report to the Bureau for Medical Services (BMS) by April 1st. This report includes a description of the services, personnel and the financial standing of THP.

The annual report is available to members by request only. To get a copy of the report, you can call Member Services at 1.888.613.8385. You can also get a copy of the report from BMS.

You have the right to:

• Ask for and obtain all included information
• Be told about your rights and responsibilities
• Get information about The Health Plan, our services, our providers, and your rights
• Be treated with respect and dignity
• Not be discriminated against by The Health Plan
• Access all services that The Health Plan must provide
• Choose a provider in our network
• Take part in decisions about your health care
• Refuse treatment and choose a different provider
• Get information on treatment options and different courses of care according to the member’s ability to understand
• Have your privacy respected
• Ask for and to get your medical records within 30 days of request
• Ask that your medical records be changed or corrected if needed within 60 days
• Be sure your medical records will be kept private
• Recommend changes in policies and procedures
• Be free from any form of restraint or seclusion used as a means of force, discipline, convenience, or retaliation
• Get covered services, no matter what cultural or ethnic background or how well you understand English
• Get covered services regardless of if you have a physical or mental disability, or if you are homeless
• Refer yourself to in-network and out-of-network family planning providers
• Access certified nurse midwife services and certified pediatric or family nurse practitioner services
- Get emergency post-stabilization services
- Get emergency health care services at any hospital or other setting
- Accept or refuse medical or surgical treatment under State law and to make an advance directive
- Have your parent or a representative make treatment decisions when you can’t
- Make complaints and appeals
- Get a quick response to problems raised around complaints, grievances, appeals, authorization, coverage, and payment of services
- Ask for a state fair hearing after a decision has been made about your appeal
- Request and get a copy of this member handbook annually after initial enrollment
- Dis-enroll from your health plan
- To exercise your rights. Exercising these rights does not adversely affect our treatment of you.
- Ask us about our Quality Improvement program and tell us how you would like to see changes made.
- Ask us about our utilization review process and give us ideas on how to change it.
- Know the date you joined our health plan
- Know that we only cover health care services that are part of your plan
- Know that we can make changes to your health plan benefits as long as we tell you about those changes in writing
- Get news on how providers are paid
- Find out how we decide if new technology or treatment should be part of a benefit
- Ask for oral interpreter and translation services at no cost to you
- Use interpreters who are not your family members or friends
- Know you will not be held liable if your health plan becomes bankrupt (insolvent)
- Know your provider can challenge the denial of service with your permission

**Your Responsibilities**

As a member of The Health Plan, you also have some responsibilities:

- Read through and follow the instructions in your member handbook
- Work with your PCP to manage and improve your health
- Ask your PCP any questions you may have
- Call your PCP at any time when you need health care
- Give information about your health to The Health Plan and your PCP
- Always remember to carry your member ID card
• Only use the emergency room for real emergencies
• Keep your appointments
• If you must cancel an appointment, call your PCP as soon as you can to let him or her know
• Follow your PCPs recommendations about appointments and medicine
• Go back to your PCP or ask for a second opinion if you do not get better
• Call Member Services at 1.888.613.8385 whenever anything is unclear to you or you have questions
• Treat health care staff and others with respect
• Tell us right away if you get a bill that you should not have gotten or if you have a complaint.
• Tell us and your DHHR caseworker right away if you have had a transplant or if you are told you need a transplant.
• Tell us and DHHR when you change your address, family status or other health care coverage.
• Know that we do not take the place of workers’ compensation insurance
Provider Reporting Requirements

Reporting of Required Reportable Diseases

Health care providers are required to report certain diseases by state law. This is to allow for both disease surveillance and appropriate case investigation/public follow-up. THP may be responsible for (1) further screening, diagnosis and treatment of identified cases enrolled in THP as necessary to protect the public’s health, or (2) screening, diagnosis and treatment of case contacts who are enrolled with THP. Detailed infectious disease reporting requirements can be obtained from the Bureau for Public Health within the Department of Health and Human Resources. The three primary types of diseases that must be reported are:

1. Division of Surveillance and Disease Control, Sexually Transmitted Disease Program. According to WV Statute Chapter 16-4-6 and Legislative Rules Title 64, Series 7, sexually transmitted diseases (STDs) are required to be reported for disease surveillance purposes and for appropriate case investigation and follow-up. For contact notification, THP must refer case information to the Division of Surveillance and Disease Control. The Division has an established program for notifying partners of persons with infectious conditions. This includes follow-up of contacts to individuals with HIV and AIDS. Once notified, contacts who are enrollees with THP may be referred back to for appropriate screening and treatment, if necessary.

2. Division of Surveillance and Disease Control, Tuberculosis Program. As per WV Statute Chapter 26-5A-4 and WV Regulations 16-25-3, individuals with diseases caused by M. tuberculosis must be reported to the WV Bureau for Public Health, DSDC, TB Program for appropriate identification, screening, treatment and treatment monitoring of their contacts.

3. Division of Surveillance and Disease Control, Communicable Disease Program. As per WV Legislative Rules Title 6-4, Series 7, cases of communicable disease noted as reportable in West Virginia must be reported to the local health departments in the appropriate time frame and method outlined in legislative rules. This both provides for disease surveillance and allows appropriate public health action to be undertaken—patient education and instruction to prevent further spread, contact identification and treatment, environmental investigation, outbreak identification and investigation, etc. (Note: Per legislative rule, reports of category IV diseases [including HIV and AIDS] are submitted directly to the state health department, not to local jurisdictions.)

Federal Reporting Requirements

The Health Plan must comply with the following Federal reporting and compliance requirements for the services listed below and must submit applicable reports to BMS. (See Medicaid Physician Provider Manual for state requirements and procedures):

- Abortions must comply with the requirements of 42 CFR 441. Subpart E – Abortions. This includes completion of the information form, Certification Regarding Abortion.

- Hysterectomies and sterilizations must comply with 42 CFR 441. Subpart F – Sterilizations. This includes completion of the consent form.

- EPSDT services and reporting must comply with 42 CFR 441 Subpart B – Early and Periodic Screening, Diagnosis, and Treatment.
Provider Responsibilities and Reimbursement

Providers must inform enrollees of the costs for non-covered services prior to rendering such services. Providers are prohibited from collecting copays for missed appointments. Please remember that enrollees are held harmless for the costs of all Medicaid-covered services provided, except for any cost-sharing obligations.

You are required to treat all information that is obtained through the performance of the services in your contract as confidential information to the extent that confidential treatment is provided under state and federal laws, rules, and regulations.

If you have any questions regarding a Medicaid member’s eligibility, please call our Customer Service at 1.888.613.8385, Monday – Friday, 8:00 a.m. to 5:00 p.m. Please remember that WV Medicaid determines eligibility for an enrollee to be in managed care.

The Health Plan encourages provider training to promote sensitivity to the special needs of this population.

The Health Plan does not discriminate against providers acting within the scope of their license. Health care professionals, acting within the lawful scope of practice, are not prohibited or restricted from advising or advocating on behalf of an enrollee’s health status; medical care or treatment options (including any alternative treatment that may be self-administered); any information the enrollee needs for deciding among all relevant treatment options; or the risks, benefits, and consequences of treatment or no treatment.

The Health Plan may not make specific payments, directly or indirectly, to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to any particular enrollee. Indirect payments may include offerings of monetary value (such as stock options or waivers of debt) measured in the present or future.

We will provide information to members regarding their rights and responsibilities and any changes upon enrollment, annually, and at least 30 days prior to any change in their benefits.

Provider Overpayments

The Health Plan is responsible for the recovery of all overpayments, including those due to fraud, waste, and abuse. In addition to internal processes to identify any overpayments, THP has a process in place for network providers to report receipt of an overpayment. The provider is required to notify THP in writing of the reason for the overpayment and return the full amount of the overpayment to THP within 60 calendar days after the date on which the overpayment was identified. In the event that THP makes an overpayment to a provider, THP must recover the full amount of the overpayment from the provider. This recovery will be administered through the claims system by offsetting the overpayment against future claims payments.

Provider Reimbursement

If a provider’s reimbursement is tied to a WV Medicaid fee schedule, THP is required to implement any rate changes adopted by BMS within 30 calendar days of notification of the rate change. THP must pay the new rate for claims not yet paid with a date of service on or after the effective date of change. The Health Plan must reprocess any claims paid between the notification date and the system load date to the updated rate. This provision does not apply to payments made to CAH under Article III, §2.7.6 or payments made to FQHCs/RHCs per Article III, §2.4.9.
Changes to Provider Fee Schedules

If a provider is reimbursed based upon the WV Medicaid fee schedule the following processes will be followed when updated rates are received from BMS.

**FQHC/RHC**

Upon BMS notification to The Health Plan of any changes to the FQHC/RHC reimbursement rates, The Health Plan must update payment rates to FQHC/RHCs to the effective date in the notification by BMS. The Health Plan must pay the new rate for any claims not yet paid with a date of service on or after the effective date of change. If payment has already been made for a claim within the current state fiscal year with a date of service on or after the effective date of the rate change, The Health Plan must reprocess the claim to reimburse at the new rate. The new payment rate must be loaded into The Health Plan’s claims payment system within thirty (30) calendar days of notification of the payment rate change.

**Critical Access Hospitals**

Upon BMS notification to The Health Plan of any changes to the CAH reimbursement rates, The Health Plan must update payment rates to CAH effective from the designated CMS effective date. The Health Plan must pay the new rate for claims not yet paid with a date of service on or after the effective date of change. The new payment rate must be loaded into The Health Plan’s claims payment system within thirty (30) days of notification of the payment rate change.

**Other BMS Fee Schedules**

(RBRVS, CLFS, Imaging, etc.)

In the case of provider reimbursement that is tied to the Medicaid fee-for-service rate schedule, The Health Plan is required to implement any rate changes adopted by the Department within thirty (30) calendar days of notification of the rate change. The Health Plan must pay the new rate for claims not yet paid with a date of service on or after the effective date of change. The Health Plan must reprocess any claims paid between the notification date and the system load date to the updated rate.
Alternative Payment Models

The Health Plan deploys several APMs for various provider types throughout our service area, including bonus payments, care coordination payments with shared savings for meeting quality measures, and total cost of care models. By analyzing multiple years of financial data, as well as three years of clinical-based analytic data, THP creates APMs that meet the "quadruple aim of health care"—that is, improving the quality of care, achieving lower costs, promoting better health outcomes, and reducing provider burnout.

THP adheres to a risk readiness approach to APMs developed by the Health Care Payment Learning and Action Network. THP seeks to meet providers and practitioners where they are on this risk continuum. To date, THP’s APMs are either category 2A through C or 3A. These APMs include payment bonuses or upside risk only. No payments are taken back or withheld from the provider(s). THP may offer shared risk APMs in the future.

THP collaborates with providers to develop APMs that are the best fit for their needs, as well as the needs of our members. THP does not have panel size requirements or other restrictions on its APMs. If your organization wishes to discuss APMs, please call 1.304.285.6508.

Marketing Guidelines

The Health Plan may conduct general advertising that does not specifically solicit the Medicaid population. The Health Plan must submit to BMS for prior written approval a marketing plan and all marketing materials prepared pursuant to said plan and the Medicaid contract.

Prohibited Marketing Practices
The following prohibitions are applicable to The Health Plan, its agents, subcontractors, and The Health Plan providers:

1. Distributing marketing materials without prior department approval;
2. Using the word, “Mountain,” or phrase, “Mountain Health,” “Health Bridge,” except when referring to Mountain Health Trust, West Virginia Health Bridge or other State programs;
3. Distributing marketing materials written above the sixth grade reading level, unless approved by the department;
4. Offering gifts valued over $15 to potential members;
5. Providing gifts to providers for the purpose of distributing them directly to The Health Plan’s potential members or currently enrolled members;
6. Directly or indirectly, engaging in door-to-door, telephone, and other cold call marketing activities;
7. Marketing in or around public assistance offices, including eligibility offices;
8. Using spam (an unwanted, disruptive commercial message posted on a computer network or sent by email);
9. Making any assertion or statement (orally or in writing) that The Health Plan is endorsed by CMS, a federal or state government agency, or similar entity;
10. Knowingly marketing to persons currently enrolled in another MCO directly by mail, phone or electronic means of communication;
11. Inducing or accepting a member’s MCO enrollment or MCO disenrollment;
12. Using terms that would influence, mislead, or cause potential members to contact The Health Plan, rather than the enrollment broker, for enrollment;
13. Portraying competitors in a negative manner;
14. Using absolute superlatives (e.g., “the best,” “highest ranked,” “rated number 1”) unless they are substantiated with supporting data provided to the department;
15. Making any written or oral statements containing material misrepresentations of fact or law relating to the The Health Plan or the Medicaid program, services, or benefits;
16. Making potential member gifts conditional based on enrollment with The Health Plan;
17. Charging members for goods or services distributed at The Health Plan or Medicaid events;
18. Charging members a fee for accessing The Health Plan’s website;
19. Influencing enrollment in conjunction with the sale or offering of any private insurance;
20. Tying enrollment in The Health Plan with purchasing (or the provision of) other types of private insurance;
21. Using marketing agents who are paid solely by commission;
22. Posting The Health Plan-specific, non-health related materials or banners in provider offices;
23. Conducting potential member orientation in common areas of providers’ offices;
24. Allowing providers to solicit enrollment or disenrollment in an MCO or distribute The Health Plan-specific materials at a marketing activity (this does not apply to health fairs where providers do immunizations, blood pressure checks, etc. as long as the provider is not soliciting enrollment or distributing plan specific The Health Plan materials.);
25. Purchasing or otherwise acquiring mailing lists from third-party vendors, or for paying department’s contractors or subcontractors to send plan specific materials to potential members;
26. Referencing the commercial component of The Health Plan in any marketing materials;
27. Discriminating against a member or potential member because of race, age, color, religion, national origin, ancestry, marital status, sexual orientation, physical or mental disability, health status or existing need for medical care, with the following exception: certain gifts and services may be made available to members with certain diagnoses;
28. Assisting with Medicaid MCO enrollment form;
29. Making false, misleading or inaccurate statements relating to services or benefits of The Health Plan or Medicaid program, or relating to the providers or potential providers contracting with The Health Plan;
30. Direct mail marketing to potential members.

**MCO Social Media Marketing Practices**

In addition to all marketing requirements outlined in this Contract, The Health Plan must comply with the social media Marketing practices as outlined below.

**Social Media Marketing Guidelines**

The following list is applicable to the MCO, its agents, Subcontractors, and MCO providers:

1. At BMS’ approval, The Health Plan may partake in forms of social media advertising (i.e. Twitter, Facebook, Instagram);
2. At BMS’ approval, The Health Plan may purchase advertisement banners on social media outlets. The content of such advertisements must be approved by BMS prior to distribution;
3. The Health Plan may post The Health Plan Medicaid events on social media sources. The content of such posts must be approved by BMS approval prior to posting;
4. The Health Plan may post general non-advertising information regarding The Health Plan activities. The content of such posts does not require BMS’ prior approval; and
5. Any enrollee complaints received through the social media sources must be processed and resolved through the general complaint intake system.
Social Media Prohibitions

The following prohibitions are applicable to The Health Plan its agents, Subcontractors, and The Health Plan providers:

1. Posting or sending any protected private information on social media source;
2. Advertising on social media platforms that entail direct communication with potential enrollees. This list includes, but is not limited to Snapchat, Skype, WhatsApp, Facebook Messenger, MeetUp, Viber, and any other personal communication services;
3. Responding to any comments on social media posts from potential enrollees except when to provide general response, such as MCO phone number, links to The Health Plan web site or the enrollment broker phone number;
4. Partaking in individual communication on social media outlets;
5. Requesting followers or adding individuals as friends (i.e. friends on Facebook, followers on Instagram or Twitter); and
6. Tagging individuals on social media source.

Reporting and Investigating MCO Marketing Violations

The Health Plan must establish a process to ensure fair and consistent investigation of alleged violations of BMS’ Marketing Policies.

Upon written receipt of any alleged MCO violation(s) from BMS, The Health Plan must:

1. Acknowledge receipt, in writing, within one (1) business day from the date of the receipt of the alleged violation.
2. Begin investigation of the alleged violation and complete investigation within fourteen (14) calendar days from the date of the receipt of the alleged violation.
3. Analyze the findings of the investigation and report findings to BMS.
West Virginia Medicaid Provider Required Provisions

The Health Plan is contracted with West Virginia Bureau for Medical Services (BMS). The West Virginia Medicaid Program requires specific contractual provisions for all contracted providers that participate with the West Virginia Medicaid program or choose to provide services to West Virginia Medicaid recipients on an intermittent basis. In addition to the terms contained within the Agreement, the following provisions are applicable specifically to Facility, Physician, Practitioner, and Ancillary Medical Care Providers that provide services to West Virginia Medicaid recipients.

A. **Obligations of Emergency Care Providers**
   - Emergency Care Providers must provide education to Medicaid members regarding the cost of their copay for non-emergency services received in the Emergency Department, including alternate locations where non-emergency can be obtained.

B. **Obligations of Providers with Respect to Member Copays**
   - Enrollees will be held harmless for the costs of all Medicaid-covered services provided except for applicable cost-sharing obligations. Providers must inform enrollees of the costs or non-covered services prior to rendering such services.
   - Providers agree that The Health Plan’s enrollees may **not** be held liable for The Health Plan’s debts in the event of The Health Plan’s insolvency.
   - In accordance with the regulatory requirements promulgated by BMS, providers may not routinely waive required copays.
   - Providers may **not** charge a copay for the following services:
     - Family Planning Services;
     - Emergency Services;
     - Behavioral Health Services;
     - Members under age 21;
     - Pregnant women (including postpartum visit);
     - American Indians and Alaska Natives;
     - Members receiving hospice care;
     - Members in nursing homes;
     - Other services excluded under State Plan Authority;
     - Members who have met their maximum cost sharing obligation per quarter; or
     - Missed appointments.
   - Providers **must** charge a copay for the following:
     - Inpatient and Outpatient Services;
     - Physician office visits;
     - Non-emergency use of an Emergency Department;
     - Caretaker relatives age 21 and above;
     - Transitional Medicaid members age 21 and above; and
     - Other members identified by The Health Plan not specifically exempt.
C. Other Obligations of Provider

- Physician may not refuse to furnish covered services to the eligible member on account of a third party’s potential liability for the service(s).

- Physician agrees to comply with The Health Plan’s Quality Assurance/Performance Improvement (QAPI) Program requirements.

- Providers that order, refer, or render covered services must enroll with BMS, through the fiscal agent, as a Medicaid provider, as required by 42 CFR 438.602(b). Enrollment with BMS does not obligate provider to offer services under the BMS fee-for-service delivery system. The Health Plan is not required to contract with a provider enrolled with the West Virginia Bureau for Medical Services that does not meet The Health Plan’s credentialing or other requirements.

- Provider must attest to the following certification for claims for Medicaid goods and services:
  - All statements are true, accurate, and complete;
  - No material fact has been omitted;
  - All services will be medically necessary to the health of the specific patient; and
  - The provider understands that payment will be from Federal and State funds and that any falsification or concealment of a material fact may be prosecuted under Federal and State law.

- Providers shall maintain malpractice insurance with minimum coverage requirements of $1 million per episode and $1 million in aggregate.

- Provider shall supply a certification that neither provider nor provider’s director(s), officer(s), principal(s), partner(s), managing employee(s), or other person(s) with ownership or control interest of five percent (5%) or more in provider have not been excluded, suspended, debarred, revoked, or any other synonymous action from participation in any program under Title XVIII (Medicare), Title XIX (Medicaid), or under the provisions of Executive Order 12549, relating to federal agreement. This certification shall state that all persons listed above have also not been excluded, suspended, debarred, revoked, or any other synonymous action from participation in any other state or federal health-care program. Provider shall notify The Health Plan immediately at the time it receives notice that any action is being taken against a physician or any other person above, as defined under the provisions of Section 1128(A) or (B) of the Social Security Act (42 USC §1320a-7), which could result in exclusion from the Medicaid program. Provider agrees to fully comply at all times with the requirements of 45 CFR Part 76, relating to eligibility for federal agreements and grants.

- Primary Care Physicians must comply with timeliness of access standards found in section 2.1.2.4 of the BMS Medicaid contract.
D. The Health Plan’s Reimbursement Responsibilities

- The Health Plan is solely responsible for payment of covered and authorized services to West Virginia Medicaid recipients as long as the member is eligible for services on the date of service. Provider shall not seek reimbursement directly from West Virginia Bureau for Medical Services.

- The reimbursement terms for West Virginia Medicaid recipients are set forth in the Provider’s Master Agreement.

- The Health Plan will not make specific payment, directly or indirectly, to provider as an inducement to reduce or limit medically necessary services furnished to any particular member.

E. Reporting Actions against Physician, Owners, or Others

- Provider must notify The Health Plan immediately after it receives notice that any action is being taken against provider or any physician, owners, persons with control interest, managing employees, partners, directors, and officers, as defined under the provisions of Section 1128(A) or (B) of the Social Security Act (42 USC §1320a-7), which could result in exclusion from the Medicaid program. The provider must agree to fully comply at all times with the requirements of 45 CFR Part 76, relating to eligibility for federal agreements and grants.

F. Compliance with Health Insurance Portability and Accountability Act

- Provider shall comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law 104-191), and the Health Information Technology for Economic and Clinical Health Act (HITECH Act) at 42 U.S.C. 17931, et. seq. Provider must treat all information that is obtained through the performance of the services contemplated by the agreement, including this amendment, as confidential information to the extent that confidential treatment is provided under state and federal laws, rules, and regulations. This expectation of confidentiality shall include, but is not limited to, information relating to applicants or enrollees of BMS programs.

G. Compliance with Deficit Reduction Act Requirements

- Provider must comply with the Section 6032 of the Deficit Reduction Act of 2005 and the SMDL 06-024. If provider receives annual Medicaid payments of at least $5 million (cumulative, from all sources), the provider must:
  
  o Establish written policies for all employees, managers, officers, contractors, subcontractors, and agents of physician. The policies must provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in Section 1902(a)(68)(A).
  
  o Include as part of such written policies detailed provisions regarding the provider’s policies and procedures for detecting and preventing Fraud, Waste, and Abuse.
  
  o Include in any employee handbook a specific discussion of the laws described in Section 1902(a)(68)(A), the rights of employees to be protected as whistleblowers, and the provider’s policies and procedures for detecting and preventing Fraud, Waste, and Abuse.
H. **Required Disclosures by Provider**

- Provider shall provide The Health Plan and BMS with all information requested of provider, including required disclosures regarding ownership and control, in accordance with 42 CFR § 455.104. In addition to any other information requested by The Health Plan or BMS, provider shall disclose the name and address of any person (individual or corporation) with an ownership or control interest in provider. In the case of individuals, such required information shall include date of birth and Social Security number for each individual having an ownership or controlling interest in Provider.

Consistent with 42 CFR § 455.101, The Health Plan defines “ownership interest” and “ownership” as follows:

- Ownership interest means the possession of equity in the capital, the stock, or the profits of provider.
- Person with an ownership or control interest means a person or corporation that:
  - Has an ownership interest totaling 5 percent or more in a disclosing entity;
  - Has an indirect ownership interest equal to 5 percent or more in provider;
  - Has a combination of direct and indirect ownership interests equal to 5 percent or more in provider;
  - Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
  - Is an officer or director of a provider practice that is organized as a corporation; or
  - Is a partner in a provider practice that is organized as a partnership.

- In addition to the required ownership and control disclosures required by 42 CFR 455.101, provider shall disclose the name of any other Medicaid-recipient organizations in which any of its owners have an ownership or controlling interest, as required by 42 CFR 455.104(b)(3).

- A provider that is a business entity, corporation, or a partnership must disclose the name, date of birth, Social Security number, and address of each person who is provider’s director, officer, principal, partner, agent, managing employee, or other person with ownership or control interest of five percent (5%) or more in the provider or in the provider’s subcontractor. The address for corporate entities must include, as applicable, primary business address, every business location, P.O. Box address, and tax identification number.

- Provider must provide information on the interrelationships of persons disclosed per 42 CFR § 455.104(b). This required information includes whether the person (individual or corporation) with an ownership or control interest in provider is related to another person with ownership or control interest in provider as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which provider has a 5 percent or more interest is related to another person with ownership or control interest in provider as a spouse, parent, child, or sibling.

- Provider agrees to keep its disclosed information regarding ownership and control current at all times by informing The Health Plan, in writing, within thirty-five (35) calendar days of any ownership or control changes.
• Provider must disclose any significant business transactions, in accordance with 42 CFR § 455.105. Provider is required to disclose full and complete information about the following information related to business transactions within thirty-five (35) calendar days of request of the Secretary of DHHS or BMS:
  o The ownership of any subcontractor with whom provider has had business transactions totaling more than $25,000 during the previous 12-month period; and
  o Any significant business transactions between provider and any wholly owned supplier, or between provider and any subcontractor, during the previous five (5) years.

• Provider must disclose any healthcare-related criminal convictions, in accordance with 42 CFR § 455.106, of any physician or provider’s director, officer, principal, partner, agent, managing employee, or other person with ownership or control interest of five percent (5%) or more in provider, relating to Medicare, Medicaid, or Title XX programs. These disclosures are required at the time that provider applies or renews its applications for Medicaid participation or at any time on request. Provider must notify The Health Plan immediately at the time provider receives notice of any such conviction. For purposes of this amendment and the underlying agreement, and consistent with 42 CFR § 1001.2, “Convicted” shall mean:
  A judgment of conviction has been entered against an individual or entity by a Federal, State or local court, regardless of whether:
  o There is a post-trial motion or an appeal pending, or
  o The judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed;
  o A Federal, State or local court has made a finding of guilt against an individual or entity;
  o A Federal, State or local court has accepted a plea of guilty or nolo contendere by an individual or entity; or
  o An individual or entity has entered into participation in a first offender, deferred adjudication or other program or arrangement where judgment of conviction has been withheld.

• Provider shall report to The Health Plan all provider-preventable conditions associated with claims.

I. Maintenance and Access of Records

• If provider places required records in another legal entity’s records, such as a hospital, the provider shall be responsible for obtaining a copy of these records for use by the government entities or their representative.

• Provider must provide to BMS:
  o All information required under The Health Plan’s managed care contract with BMS, including but not limited to the reporting requirements and other information related to
a provider’s performance of its obligations under its provider contract with The Health Plan; and

- Any information in provider’s possession sufficient to permit BMS to comply with the federal Balanced Budget Act of 1997 or other federal or state laws, rules, and regulations. If provider places required records in another legal entity’s records, such as a hospital, provider is responsible for obtaining a copy of these records for use by the above-named entities or their representative.

**J. Use of Information Obtained Through Agreement**

- The provider shall not use information obtained through the performance of The Health Plan agreement, or this amendment, in any manner except as is necessary for the proper discharge of obligations and securing of rights under the agreement.

**K. Prohibition against Direct Marketing**

- Provider is prohibited from engaging in direct marketing to enrollees that is designed to increase enrollment in The Health Plan. This prohibition does not constrain Provider from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance.

**L. Non-Interference with Rights of The Health Plan and the State**

- Provider shall take no actions that interfere with or place any liens upon the State’s right or The Health Plan’s right, acting as the State’s agent, to recovery from third-party resources.

**M. Compliance with Advance Directives Requirements**

- Provider shall comply with 42 CFR § 422.128 and West Virginia Health Care Decisions Act relating to advance directives.

**N. Right to Recover Overpayments from Provider**

- Provider shall notify The Health Plan, in writing, of any overpayment discovered by Provider. This required notification shall include the reason for any overpayment. Provider shall return the full amount of the overpayment to The Health Plan within sixty (60) calendar days after the date on which the overpayment was identified.

- BMS has the right to recover provider overpayments, including those overpayments due to Fraud, Waste, and Abuse, from provider if:
  - BMS or its contractor identifies an overpayment made by The Health Plan to provider;
  - The payment occurred outside the grace period, as defined by BMS;
  - The Health Plan has not previously identified the overpayment via the deconfliction process outlined herein;
  - The Medicaid Fraud Control Unit (MFCU) or other law enforcement entity is not pursuing provider; and
  - BMS, in its sole discretion, determines it is unable to collect from The Health Plan.

In the event the State collects overpayments directly from provider, provider’s appeal rights are outlined in the BMS policy manual Chapter 800(B), which can be found on the BMS website.
Drug Testing Policy

Effective July 1, 2018, based on The American Society of Addiction Medicine (ASAM) published consensus statement, The Health Plan updated the guideline related to review of clinical drug testing for addiction treatment programs and pain management programs for all lines of business. Full ASAM guidelines can be found on the ASAM website.

The Health Plan follows the benefit limits established by BMS:

- Code limit for presumptive drug screens (80305, 80306, and 80307) is now 24 in combination per calendar year. Medical necessity authorization is required beyond service limits.
- Code limit for definitive drug screens (G0480, G0481, and G0482) is now 12 in combination per calendar year. Medical necessity authorization is required beyond service limits.
- G0483-definitive drug testing for 22 or more drug classes requires medical necessity prior authorization from the INITIAL service prior to service being rendered unless it is the result of an emergency room visit.
- G0659-definitive drug testing to identify drugs that do not have a specific test available requires medical necessity prior authorization from the INITIAL service prior to services being rendered.
- To exceed the benefit limit, providers must contact The Health Plan to obtain a medical necessity authorization.

The complete policy can be located on the BMS website.

Breathalyzer Testing

Effective July 1, 2020, The Health Plan will deny all breath alcohol testing (procedure code 82075) performed in conjunction with any urine drug screen other than dipstick point of care testing (POCT), billed with procedure code 80305. Providers using more complex urine drug testing such as procedure code 80307 or a definitive screen are encouraged to include alcohol as a screened substance.

The Health Plan made this change in order to ensure the proper utilization of urine drug testing associated with pain management clinics and substance use disorder practitioners and facilities. We would like to remind providers that urine drug testing is most effective when 1) individualized rather than routine, 2) randomized, and 3) conducted in conformance with principles of assessment recommended by the American Society for Addiction Medicine.

ASAM strongly recommends against routine use of definitive testing. Please review the white paper at the link above. As always, all clinical procedures can be subject to post payment review of medical necessity.
Transplant
Members receiving transplant services will be transitioned back to fee-for-service.

Non-Par Provider
Non-participating providers must obtain prior authorization for claims to be reimbursed.

Prior Authorization
Effective January 1, 2017, all providers are required to request prior authorization before a service is rendered. This requirement includes both outpatient and inpatient services. If service is rendered after hours, over the weekend or on a holiday, providers are required to request authorization the next business day. Prior authorization requests received after the next business day will not be processed. Failure to follow prior authorization guidelines will result in denied claims.

Chiropractic Service
Manipulation and X-ray procedure codes along with 99201, 99202, and 99203 will be covered per contract. Effective April 1, 2020 physical therapy codes have been added as a covered service. Benefit limits are still in effect.

Physical and Occupational Therapy
Therapy codes are not payable without one of these modifiers to distinguish the discipline of the plan of care under which the service is delivered.

- **GO**: Indicates services delivered under an outpatient occupational therapy plan of care
- **GP**: Indicates services delivered under an outpatient physical therapy plan of care

Inpatient Claims
In order to be consistent with the payment policies currently utilized by CMS for Medicare, Medicaid’s fiscal agent for WV Medicaid, and general industry standards for commercial payors, THP changed our claims processing policy regarding hospital and skilled nursing inpatient admissions. **Effective July 1, 2017**, THP began processing payments for inpatient admissions based on the discharge date of the inpatient stay. This affects any claim for an inpatient admission where the reimbursement terms of our contract are based upon a DRG, case rate, per diem or percent of billed charges methodology.
NDC Rebate Eligible Drugs

The Health Plan cannot reimburse for drugs, drug products, and related services, which are defined as a non-covered benefit by the department’s outpatient drug pharmacy program.

In accordance with 42 U.S.C. § 1396r-8, THP must exclude coverage for any drug marketed by a drug company (or labeler) that does not participate in the federal drug rebate program. THP is not permitted to provide coverage for any drug product, brand name or generic, legend or non-legend, sold or distributed by a company that did not sign an agreement with the federal government to provide Medicaid rebates for that product.

The Medicaid drug rebate program was created by the Omnibus Budget Reconciliation Act of 1990 (OBRA ’90) which added Section 1927 to the Social Security Act and became effective on January 1, 1991. The law requires that drug manufacturers enter into an agreement with the Centers for Medicare and Medicaid Services (CMS) to provide rebates for their drug products that are paid by Medicaid. Manufacturers that do not sign an agreement with CMS are not eligible for federal Medicaid coverage of their products. Since 1991, it has been required that outpatient Medicaid pharmacy providers dispense only rebateable drugs and bill with the NDCs. Now, with the Deficit Reduction Act of 2005, this requirement is being expanded to include physician-administered drugs.

Drugs administered by the physician and billed with an NDC must be rebateable in order to be eligible for payment, otherwise the drug will be denied. Providers can refer to the CMS website to determine if an NDC is manufactured by a company that participates in the federal drug rebate program or consult your wholesaler for assistance. **Failure to submit all required information such as NDC code, unit of measurement and quantity will result in a complete claim denial** (see provider billing instructions for requirements).

Unit of Measurement codes are:

- F2 - International Unit
- GR - Gram
- ML - Milliliter
- UN - Unit

340b providers are required to use modifier **UD** when submitting claims.

**FAQs** related to this requirement can be found on the Bureau for Medical Services website.
Readmissions Review Occurring Within 30 Days

Effective November 1, 2018, all clinically related/potentially preventable readmissions occurring within a thirty (30) day period are subject to review and denied in the event it is determined that the patient was prematurely discharged from the same hospital, the facility failed to have proper and adequate discharge planning in place, or if there was a lack of proper coordination between the inpatient and outpatient health care teams. In the absence of information to determine the appropriateness of the readmission from hospital review staff, submitted records or physician contact with the plan, clinically related/potentially preventable readmissions within a seven (7) day period will be automatically denied and the provider will need to provide medical documentation to support the need for payment. Final review decisions will be made/confirmed by an employed medical director of The Health Plan.

Wrong procedures or procedures performed on the wrong side, wrong body part, or wrong person, are commonly referred to as “never events.” As a reminder, all never events are considered not medically necessary and reimbursement is not allowed. Questions regarding claim denials may be directed to The Health Plan’s provider number at 1.877.847.7901.

See Section 7 of this Manual for information on THP’s 30 Day Hospital Readmission Utilization Management Review Guideline. See Section 12 of this Manual for billing guidelines related to readmissions occurring within 30 days of discharge from an inpatient facility.
SUD Provider Training and Education Requirements

SUD providers are responsible for providing training and education to their staff on the ASAM® Level of Care criteria and the application of the ASAM® criteria in the assessment process. During provider enrollment, The Health Plan will obtain attestation from the SUD provider that ASAM® criteria will be applied appropriately by the provider’s SUD program staff. As part of BMS’ quality monitoring strategy, personnel and clinical records of a sample of the provider network will be reviewed to evaluate if there is appropriate application of and fidelity to the ASAM® Levels of Care and the Medicaid Provider Manual. BMS’ ASO contractor will perform these retro reviews of providers to ensure SUD program providers are consistently applying ASAM® criteria throughout an individual’s stay and that documentation and personnel records meet established Medicaid standards.

ER All-Inclusive

THP is following the requirements outlined in the BMS hospital manual around the all-inclusive rate for emergency services.

Medicaid covers five levels of emergency room services. There are five CPT procedure codes available for billing emergency room services.

The enhanced reimbursement is an all-inclusive fee, which is considered to include the following items:

- 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.
Outpatient Services for Acute and Critical Access Hospitals

Effective January 1, 2020, CPT/HCPCS codes are required to be submitted with the applicable revenue code for all outpatient services. Revenue codes that are submitted without the corresponding procedure code will be denied.

Surgical procedures must be billed with the appropriate CPT or HCPCS code and revenue code. Units are reported in fifteen (15) minute time increments. Charges and total time units for the procedure(s) must be rolled to the primary, most complex procedure and billed on one line. If you wish to report multiple procedures, bill all additional lines with zero units and zero charges.

Paper Claim Submissions

For paper claim submitters, The Health Plan accepts the current standard paper claim billing forms:

- CMS 1500 (02/12) professional claim form
- UB-04 hospital claim form
- ADA dental claim form

Effective July 1, 2020, only original claim forms (red ink) are accepted. Copies made from an original claim form, faxed or scanned claims (black ink) will be rejected.

Handwritten claims are also not acceptable. As an alternative to paper claims providers may submit claims electronically, free of charge, via The Health Plan’s provider portal. Contact your provider engagement representative to learn how. You may access contact information for the provider engagement representative assigned to your county by viewing the territory map located at https://www.healthplan.org/providers/overview/meet-provider-engagement-team.

Claim forms must be completed in their entirety. The Health Plan requires that all claims are submitted with accurate and current CPT-4, HCPCS, and ICD-10 codes, as appropriate.
<table>
<thead>
<tr>
<th>Members</th>
<th>Value Add</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to CoreWellness. Online tool to help members learn ways to get and stay healthy</td>
<td></td>
</tr>
<tr>
<td>Health risk assessments</td>
<td></td>
</tr>
<tr>
<td>Dedicated care managers to help members manage medications, disease and improve overall health</td>
<td></td>
</tr>
<tr>
<td>Specialized care managers for neonatal abstinence syndrome (NAS), NICU, high-risk obstetrics, hepatitis, and behavioral health. Face-to-face care management with high-risk members with specialized care managers</td>
<td></td>
</tr>
<tr>
<td>One-on-one education with asthma nurse educator</td>
<td>Asthma pack with peak flow meter, spacer and carrying pack</td>
</tr>
<tr>
<td>HbA1c blood test, nephropathy exam and diabetic eye exam for diabetics (all three required)</td>
<td>$50 Gift Card</td>
</tr>
<tr>
<td>Diabetes education by case managers</td>
<td></td>
</tr>
<tr>
<td>One-on-one education by diabetes educators on glucometer, insulin pump use and general diabetes education</td>
<td></td>
</tr>
<tr>
<td>Unlimited calls to Member Services and free wellness and appointment reminder texts</td>
<td>Cell phone with minutes for text &amp; voice</td>
</tr>
<tr>
<td>Personal assistance with applying for SSI</td>
<td></td>
</tr>
<tr>
<td>One-on-one help to quit smoking with a certified counselor</td>
<td></td>
</tr>
<tr>
<td><em>Members 12 &amp; older</em>: Quit smoking packets with workbook, relaxation exercises and quit smoking survival kit</td>
<td></td>
</tr>
</tbody>
</table>
### Pregnant, New Moms & Mothers

<table>
<thead>
<tr>
<th>Maternity Outreach Program:</th>
<th>Value Add</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 1st trimester (up to 2 visits)</td>
<td>$50 Gift Card</td>
</tr>
<tr>
<td>• 3rd trimester (up to 4 visits)</td>
<td>$50 Gift Card</td>
</tr>
<tr>
<td>• Post-partum visit (between 7-84 days after delivery)</td>
<td>$50 Gift Card</td>
</tr>
</tbody>
</table>

Care coordination through baby’s 1st year for mother’s with high-risk pregnancies

Care coordination through baby’s 1st year for mother’s with substance use disorder during pregnancy

Text4Baby messages to keep mom and baby healthy

NICU babies or babies with complex conditions

Preventive dental (up to 2 visits, mothers 21+)

### Children

<table>
<thead>
<tr>
<th>Value Add</th>
</tr>
</thead>
</table>

Dental exam 2 – 3 years of age | $25 Gift Card |

Yearly well visit 3 – 6 & 12 – 21 years of age | $25 Gift Card |

Camp Kno Koma — Diabetes | Scholarship(s) |

---

### Help in your language

Do you need help communicating with us or reading what we send you? We provide our letters in other languages and large print at no cost to you. Call our toll-free Customer Service Department at 1.888.613.8385 (TTY: 711).
Section 6

Office Copays, Medical Copays, Co-insurance & Deductibles
Office Visit Copays, Medical Copays, Co-insurance & Deductibles

The Health Plan offers a variety of benefit plans that require the member to be responsible for a portion of the cost of services. Member responsibility may take the form of copays for office visits or other medical services, co-insurance amounts, and deductibles. As groups re-enroll annually, the member copayment may change, depending upon the plan selected by the employer.

### Office Visit Copay/Medical Copay

Generally, copays are a fixed amount, but may be a percentage of the allowed amount that is associated with a specific service such as an office visit, therapy visit, or diagnostic service and would be the member’s responsibility. Members are expected to pay this amount at the time of service.

It is imperative that the offices ask for the member’s ID card at every visit. A sample of The Health Plan ID card is shown on the product matrix located in Section 3.

Copays may not be waived, as this is in direct violation of the provider’s contract.

The copay should be collected at the time of service, unless other arrangements have been made.

Copays DO NOT apply to hospital inpatient physician visit, preventive services and/or prenatal office visit (after the initial visit), physician nursing home visits, or patient home visits when determined to be medically necessary by the plan. Members of specific employer groups may have a copay for specific outpatient procedures.

### Co-insurance

Generally, co-insurance is an amount based upon the member being responsible for a percentage of the allowed amount for a covered service. A provider may request payment at the time of service. However, the provider must take care to determine the member’s specific benefit and apply any contract reimbursement terms to determine the amount of the co-insurance. At no time should a provider collect more than the amount that is contractually obligated to be paid. The most accurate method to assure that the provider is collecting the correct amount may be to wait for the explanation of benefits (EOB) from The Health Plan showing the amount that is member responsibility. A copy of the EOB is also sent to the member letting them know the amount that is their responsibility.

### Deductibles

Deductibles are an annual amount, defined by the member’s benefit plan that members must satisfy before the plan pays for any services. A provider may expect payment from the member at the time of service, if the member has not satisfied their annual deductible. However, unless, the member knows that they have not met their deductible, it is generally difficult, due to claims lag, to determine if a member has met their deductible at any given point in time. At no time should a provider collect more than the amount that is the member’s responsibility.
Collecting copays when another insurance is primary

If the primary insurance pays equal to, or more, than the office copay amount, do not collect The Health Plan office copay.

Example: Member has a $10.00 copay and his primary insurance carrier pays $11.00, do not collect the $10.00 copay.

If you have questions regarding whether or not to collect office copay, please contact The Health Plan Coordination of Benefits/Funds Recovery Department at 1.740.695.7903 or 1.800.624.6961, ext. 7903.

Determining a member’s responsibility

Member copays for physician office visits and certain other services may be found on The Health Plan’s provider secure portal myplan.healthplan.org or by calling The Health Plan Customer Service Department at 1.800.624.6961.

PLEASE NOTE: Deductible and coinsurance are not applicable for preventive services.

The Affordable Care Act (ACA) requires private insurers to cover certain preventive services without any patient cost-sharing. The Health Plan products affected by the ACA would be our commercial, HMO, PPO, POS, and self-funded employer groups.

Under the ACA, private health plans must provide coverage for a range of preventive services and may not impose cost sharing (such as copayments, deductibles, or co-insurance) on patients receiving these services. Please remember that annual well exams and other preventive services do not require a copay or coinsurance from the member, unless the employer group to which they belong, is “grandfathered.”

Information about Medicare Preventive Services can be found on the CMS website.
Quick Reference of CPT Codes for Office Encounters

Office copays are usually applied to all services representing a face-to-face encounter with the physician or physician extender, except for surgical care and preventive services.

The following list of CPT codes represents the codes most frequently used to describe these services. This list represents most frequently used but is not all-inclusive.

<table>
<thead>
<tr>
<th>OFFICE MEDICAL SERVICES</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>99368</td>
<td>99394</td>
</tr>
<tr>
<td>99202</td>
<td>99381</td>
<td>99395</td>
</tr>
<tr>
<td>99203</td>
<td>99382</td>
<td>99396</td>
</tr>
<tr>
<td>99204</td>
<td>99383</td>
<td>99397</td>
</tr>
<tr>
<td>99205</td>
<td>99384</td>
<td>99401</td>
</tr>
<tr>
<td>99211</td>
<td>99385</td>
<td>99402</td>
</tr>
<tr>
<td>99212</td>
<td>99386</td>
<td>99403</td>
</tr>
<tr>
<td>99213</td>
<td>99387</td>
<td>99404</td>
</tr>
<tr>
<td>99214</td>
<td>99391</td>
<td>99411</td>
</tr>
<tr>
<td>99215</td>
<td>99392</td>
<td>99412</td>
</tr>
<tr>
<td>99366</td>
<td>99393</td>
<td>99420</td>
</tr>
<tr>
<td>99367</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AUDIOLOGIC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>92557</td>
<td>92593</td>
<td>V5008</td>
</tr>
<tr>
<td>92590</td>
<td>92594</td>
<td>V5010</td>
</tr>
<tr>
<td>92591</td>
<td>92595</td>
<td>V5020</td>
</tr>
<tr>
<td>92592</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CONSULTATIONS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99241</td>
<td>99243</td>
<td>99245</td>
</tr>
<tr>
<td>99242</td>
<td>99244</td>
<td></td>
</tr>
<tr>
<td>OPHTHALMOLOGY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>92002</td>
<td>92012</td>
<td></td>
</tr>
<tr>
<td>92004</td>
<td>92014</td>
<td></td>
</tr>
<tr>
<td>OTORHINOLARYNGOLIC SERVICES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>92506</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SPECIAL SERVICES / REPORTS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99058</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Section 7

Clinical Services
Clinical Services Introduction

The medical management program ensures the provision of appropriate health care to its members while addressing the effectiveness and quality of the care. The delivery of health care services is monitored and evaluated to identify opportunities for improvement. The program provides for a systematic process to promote the access of medically appropriate, holistic care in a timely, efficient manner across the network through population health-driven care, complex case navigation, prior authorization, admission and concurrent reviews, health and wellness programs, chronic disease management and pharmacy programs.

The primary goal of the medical management program is to measurably improve the utilization of care and services to our members in a way that is financially responsible and responsive to their individual health care needs. This goal is achieved by meeting the following objectives:

- Promote and provide appropriate allocation of health care services to our members.
- Perform utilization management processes with minimal disruption to the delivery of care and services, including clinical information gathering, documentation review, and communication of utilization management decisions.
- Identify members for social service referrals, care navigation assistance, complex case management, and high risk perinatal and chronic disease navigation programs.
- Assess medical management program performance by soliciting input from members and practitioners through surveys annually.
- Develop interventions based on input received from members and practitioners to improve the quality of services to all customers.
- Educate practitioners on the scope of the medical management program and Clinical Services Division.

Medical Prior Authorization & Notification Requirements

The Medical Prior Authorization and Notification Requirements are available here.
Palladian Health

Palladian Health is performing prior authorization and medical necessity review for musculoskeletal conditions and spine pain management.

This change affects all providers treating back pain and musculoskeletal conditions including chiropractors, physical therapists, occupational therapists, surgeons, orthopedists, neurologists, neurosurgeons, pain management specialists and clinics, physiatrists and anesthesia pain management specialists.

Medical necessity review and prior authorizations may be completed through The Health Plan’s online provider portal, via fax at 1.844.681.1205 or telephonically at 1.877.244.8514.

Questions on this process may be addressed by calling THP’s provider number at 1.877.847.7901 or by contacting your Provider Engagement Representative.

As part of our commitment to providing programs that support THP’s Population Health Management initiatives, The Health Plan has partnered with Palladian Health to provide an evidence-based approach to coordinating and managing the treatment of musculoskeletal conditions and spine pain. The program focuses on improving health outcomes and ensuring appropriate treatment while engaging patients through a care advocacy program. The care advocacy program includes patient outreach, support and education, provides web-based self-management education, and a cognitive behavioral therapy telehealth program.

Palladian Health performs prior authorization and medical necessity review as follows:

- **All services related to spine care management**, (including injections, spinal surgeries, and spinal stimulation, etc.) require prior authorization and medical necessity review by Palladian Health
  - Includes all commercially insured fully funded plans (including HMO, PPO and POS plans), all Medicaid plans, and all Medicare Advantage plans.
  - Participants in self-funded plans are not included in this program
  - Diagnostic imaging reviews, MRI, etc., are reviewed for medical necessity and prior authorized by eviCore health care.
- **PT and OT** - the first 20 combined visits for physical therapy (PT) and occupational therapy (OT) per event and/or year do not require prior authorization.
- Palladian Health will review services for medical necessity and determine authorization status beginning with the 21st **combined** PT/OT visit.
- **Chiropractic care** - the first 20 visits for chiropractic services per event and/or year do not require prior authorization
  - Palladian Health will complete medical necessity review beginning with the 21st chiropractic visit.
  - **All X-rays performed in the chiropractic setting require prior authorization**
  - Visit limitations for THP Medicaid and Medicare lines of business will follow a calendar year.
  - Commercial plan (including HMO, POS, PPO and WV PEIA) visit limitations will be based on a contract year.
  - Self-Funded plans are excluded and default to the group plan document.
eviCore healthcare

The Health Plan has entered into a partnership with eviCore healthcare to manage medical necessity and prior authorization for the following services for all Medicaid, Medicare and fully insured lines of business. Services performed in conjunction with an inpatient stay, 23-hour observation, or emergency room visit are not subject to authorization requirements.

For urgent requests: If services are required in less than 48 hours due to medically urgent conditions, please call 877.791.4104 for expedited authorization reviews. Be sure to tell the representative the authorization is for medically urgent care.

This prior authorization and review process does not include services provided to participants in self-funded plans – please check plan benefits for coverage and prior authorization requirements.

- **Sleep Studies**
- **Durable Medical Equipment (DME)**
- **Radiology/Cardiology**
  - CT / CTA
  - MRI / MRA
  - PET / PET CT
  - Myocardial Perfusion Imaging (Nuclear Stress)
  - Echo / Echo Stress
  - Diagnostic Heart Cath
  - Cardiac Imaging (CT, MRI, PET)
  - Cardiac Rhythm Implantable Device (CRID)
- **Post-Acute Care (Medicare/DSNP ONLY)**
  - Skilled nursing
  - Home health (all services)
  - Long term acute care
  - Inpatient rehab

Access to the list of CPT codes that require prior authorization are located at evicore.com along with eviCore healthcare’s clinical guidelines and request forms.

Services performed without authorization may be denied for payment, and you may not seek reimbursement from members.
## Telephone Directory

<table>
<thead>
<tr>
<th>Service</th>
<th>During Business Hours (8 a.m to 5 p.m.)</th>
<th>After Hours Urgent/Emergent Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admissions</td>
<td>1.800.304.9101</td>
<td>1.866.NURSEHP (1.866.687.7347)</td>
</tr>
<tr>
<td>Benefit/Eligibility</td>
<td>1.877.794.7152</td>
<td></td>
</tr>
<tr>
<td>Urgent or Emergent Notification UM Support</td>
<td>1.877.794.7152</td>
<td></td>
</tr>
<tr>
<td>24/7 Availability – reverts to voicemail after hours</td>
<td>1.877.794.7152</td>
<td></td>
</tr>
<tr>
<td>Prior authorizations</td>
<td>Fully Funded: 1.877.847.7902</td>
<td>1.866.NURSEHP (1.866.687.7347)</td>
</tr>
<tr>
<td></td>
<td>ASO: 1.888.816.3096</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medicare: 1.877.847.7907</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medicaid: 1.888.613.8385</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Palladian: 1.877.244.8514</td>
<td></td>
</tr>
<tr>
<td></td>
<td>eviCore: 1.877.791.4104</td>
<td></td>
</tr>
<tr>
<td>*Online submission for prior authorization is available at <a href="http://myplan.healthplan.org">myplan.healthplan.org</a></td>
<td>1.888.329.8471</td>
<td></td>
</tr>
<tr>
<td>Fax Number–Clinical information for referral review</td>
<td>1.330.830.4397</td>
<td></td>
</tr>
<tr>
<td>Fax Number–Hospital demographics and clinical reviews</td>
<td>1.888.329.8471</td>
<td></td>
</tr>
<tr>
<td>Medical Directors</td>
<td>1.800.624.6961, ext. 7644</td>
<td>1.866.NURSEHP (1.866.687.7347)</td>
</tr>
<tr>
<td>Administrative Assistant</td>
<td>1.800.624.6961, ext. 7644</td>
<td></td>
</tr>
<tr>
<td>Medical Emergency Nurse Line available 24/7</td>
<td>1.800.624.6961</td>
<td>1.866.NURSEHP (1.866.687.7347)</td>
</tr>
</tbody>
</table>
**Nurse Information Line**

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

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

You can contact the nurse information line by calling a nurse navigator directly at 1.866.NURSEHP (1.866.687.7347).

**Admissions/Concurrent Review Process**

**Prior authorization of elective admissions** is performed to confirm eligibility, benefits, and medical appropriateness of services to be rendered and level of care to be utilized. The process is initiated by the member’s primary care physician (PCP) or referring participating specialist with the Medical Department’s nurse navigators. This includes acute care, rehabilitation, skilled nursing facilities and long-term acute care facility (LTACF).

**Notification of urgent/emergent admissions**, by the admitting physician or facility, is required at the time of, or as soon as practically possible after admission into an acute care facility. This activity is performed for early discussion of member’s needs as related to the admission or alternative health care services.

**All out-of-plan and tertiary non urgent/emergent requests require prior authorization.** Clinical information is reviewed for availability of service within the plan’s network, clinical complexity, or other extenuating circumstances and should be supplied by the PCP or appropriate in-plan specialist (if referring within their specialty). This includes acute care, long-term acute care facilities (LTACF), rehabilitation, and skilled nursing facilities.

**Concurrent review** is the process of continued reassessment of medical appropriateness for inpatient care. Any member identified with potential discharge planning needs is referred by the Medical Management Department’s inpatient navigator to case navigation, chronic disease navigation or the social workers as appropriate for early intervention. Concurrent review is performed by fax or telephonically and involves communication with physicians, hospital utilization review (UR) staff, social workers and family members as necessary.

The process of concurrent review utilizes nationally recognized criteria for inpatient admissions and continued stay. It is understood that the criteria cannot be applied to all cases. All factors such as the member’s age, living conditions, support systems and past medical/surgical history are considered in applying criteria.

**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.
30 Day Hospital Readmission Utilization Management Review Guidelines

Policy Overview: This administrative policy is applicable to in-network facilities based on a contracted DRG or case rate methodology for all of The Health Plan’s fully funded lines of business and ASO groups or plans utilizing The Health Plan Network at participating network facilities. It defines payment guidelines for readmissions to an acute general short-term hospital occurring within thirty (30) calendar days of the date of discharge from the same acute general short-term hospital for the same, similar or clinically related diagnoses. In the instance of multiple readmissions, each admission will be reviewed against criteria relative to the immediately preceding admission.

Definitions:

- **Clinically Related** – an underlying reason for subsequent admission that is plausibly related to the care rendered during or immediately following a prior hospital admission. A clinically related readmission may involve the same or similar diagnosis or DRG group and may have resulted from the process of care and treatment during the prior admission (e.g. readmission for surgical wound infection, or readmission for appendectomy following an admission for abdominal pain with fever) or from lack of or improper post admission care coordination (e.g. failure to transmit orders to home infusion provider for antibiotics necessitating readmission) rather than from unrelated events that occurred after the prior admission (e.g. broken leg due to trauma following a medical admission).

- **Readmission** – an admission to the hospital occurring within 30 days of the date of discharge from the same hospital. For the purpose of calculating the 30-day readmission window the day of discharge is not counted.

Policy Statement

The Health Plan Medical Management Department shall conduct hospital readmission review to determine if the readmission was considered clinically related to the previous admission. Readmissions determined to be clinically related to the previous admission will not be separately reimbursed. Facilities will be notified that readmission authorization is denied for clinically related criteria and the previously approved inpatient authorization will be updated to cover the second stay. Facilities will receive written notice and instructions regarding how to submit a corrected claim.

Clinically Related Criteria:

- 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 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.
Exclusions from hospital readmission review are:

- Transfers from out of network to in-network facilities
- Transfer of patients to receive care not available at the first facility
- Readmissions that are planned for repetitive or staged treatments, such as cancer chemotherapy, transfusions for chronic anemia or staged surgical procedures
- Readmissions associated with malignancies (limited to those who are in active chemotherapy regimens), burns, or cystic fibrosis
- Readmissions for primary psychiatric disease
- Relapses for SUD causing readmission
- Readmission due to bone marrow transplants
- Admissions to skilled nursing facilities (SNF), long term acute care facilities (LTAC) and inpatient rehabilitation facilities (IRF)
- Readmissions where the first admission had a discharge status of “left against medical advice"
- Readmissions greater than 30 days from the date of discharge of the first admission
- Readmission for patients under 12 months of age at time of service
- Obstetrical readmissions

Refer to Section 12 for billing guidelines related to inpatient readmissions occurring within 30 days.
Prior Authorization/Referral 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, his/her circumstances, medical history, and availability of care and services within The Health Plan network. Input is sought annually, or as needed, in the review of criteria from physicians in the community and those who serve as members of the physician advisory committee. In cases where specific clinical expertise is needed to perform a review, or an appeal is presented, reviews are sent to a contracted URAC or NCQA accredited vendor for specialty medical review services by board-certified physician reviewers with the same or similar background.

InterQual® Review

The Health Plan utilizes Change Healthcare InterQual® criteria as a screening guideline to assist reviewers in determining medical appropriateness of health care services. Any participating provider/practitioner, upon request, may review the specific criteria used in an active clinical review process of a procedure requiring the use of InterQual®. You may call The Health Plan’s Clinical Services Department if you have a general InterQual® question or a question regarding a particular type of care. InterQual® review worksheets are available upon request.

The Health Plan uses InterQual® guidelines for most procedures and services other than for Medicaid Groups where West Virginia’s Bureau of Medical Services has mandated use of other criteria for specific services. Refer to The Health Plan’s prior authorization list for specific details.

Primary care physicians (PCP) are responsible for directing care to specialty care physicians. The Health Plan does not require a referral to an in-plan specialist in most instances.

Please refer to the complete listing of in-plan services that require prior authorization and/or notification. Remember, additional services may require prior authorization based on specific plan requirements of some groups, especially those that are self-funded. Also, due to changes in medical technology and the accessibility of diagnostic equipment and services in an office/outpatient setting, as well as updated methods or approaches to performing procedures and services, there may be additional services that will require medical review. Contact The Health Plan if you have concern regarding a particular procedure or test.

The following are examples of services that require prior authorization:

- **Ancillary services** require prior authorization by the Medical Department through the referral process. Some services that require prior authorization include, **hospice and durable medical equipment (DME) including all customizations and add-ons**. In addition, all DME repairs and replacements require prior authorization.

- **Diagnostic testing and imaging studies** require prior authorization and medical appropriateness review, including but not limited to **MRI/MRA and CT scans (including cardiac advanced imaging)**, **PET and PET/CT fusion scan**, and **SPECT MPI ordered by non-cardiologists**.
All out-of-plan and tertiary requests require prior authorization. Clinical information is reviewed for availability of service within the in-plan network, medical necessity, clinical complexity, and other extenuating circumstances that should be supported by the PCP or appropriate in-plan specialist’s documentation (if referring within their specialty). Please refer to The Health Plan list of tertiary providers to assist you in directing members to appropriate providers.

All genetic testing requires prior authorization. This includes, but is not limited to, all prognostic gene expression profiling techniques, all gene and molecular expression assays, and all genetic testing for inherited susceptibility for a disease.

When genetic testing is being considered, it is imperative that the testing be authorized prior to completing laboratory requisitions. Information needed to obtain prior authorization for testing includes:

- Patient displays clinical features or is at direct risk of inheriting the mutation in question.
- Result of the test will directly impact the treatment being delivered to the patient.
- Documentation of a comprehensive history, physical examination, genetic counseling as indicated, and completion of conventional diagnostic studies.
- Genetic tests should be completed at an in-plan laboratory.
- Genetic testing is reviewed using nationally recognized criteria for molecular diagnostics.

Authorization can be obtained via telephone, fax or electronically through our provider portal. Prior authorization request forms are available on the provider portal under “Forms.”

Additional services that require prior authorization include procedures that may have limited coverage under the plan benefits or that may be deemed experimental/investigational for some diagnoses. Also, high cost procedures and new technologies that have specific coverage guidelines must be prior authorized to assure medical appropriateness and compliance with established standard of care guidelines. Cosmetic procedures are not covered. Please contact The Health Plan Customer Service Department if you have any concern regarding coverage of any service at 1.800.624.6961.

Please refer to the Behavioral Health Department and Pharmacy Department sections of this manual for specific information regarding the process for prior authorization of those services.

Any prior authorization that does not meet medical appropriateness review by the nurse navigator is referred to the medical director for review determination. The medical director may contact the PCP, consulting physician, or specialist for case discussion. Availability of services within the provider network and alternative levels of care for services may be offered as appropriate to the member’s needs.

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.

Providers shall be informed of service and authorization requirement changes (include site of service changes) no less than 30 days prior to the implementation of such changes.
Requests for Second Opinion

Most “second opinion” evaluations may be achieved within the member’s local network. In the event the services requested are not available locally, a tertiary level “second opinion” may be considered.

When requesting a second opinion at a tertiary facility, please understand that this request authorizes an evaluation visit only and that any further visits, surgery, treatment, and testing would require additional prior authorization.

Once the evaluation is completed, the consulting physician should send his/her report back to the referring physician, who will then discuss findings with the member.

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.
Specialist Coordination of Health Care Services

(Standing Referrals, Specialist Referrals and Secondary Care Providers)

It is the policy of The Health Plan to facilitate ongoing specialist care and coordination of the benefit for appropriate members. This would apply when the primary care practitioner, in consultation with a specialist practitioner, identifies the need for specialty care for a condition that is life-threatening, degenerative, or disabling.

The PCP is responsible for initiating a specialist referral if one is required and supplying appropriate member history to the specialist. A treatment plan is formulated by both physicians and the member. The plan of care is subject to review by the Medical Department.

Short-term specialist care (six months or less) is requested upon a specialist referral form (‘SR’ referral type), if required by the enrollee’s group or specialist physician. Ongoing care over an extended period of time is requested on a standing referral (‘SG’ referral type). This is typically seen with tertiary or approved single case agreement provider referrals. The number of visits shall be based upon the treatment plan and shall be limited to a one-year period.

Additionally, some members may choose to list a Secondary Care (Specialist) Provider (SCP). When the member’s care cannot be delivered in the primary care setting due to complexity of care or a particular disease process, the member may choose to select an in-plan participating specialist as SCP. Examples of a SCP may include endocrinology, oncology, nephrology or cardiology. Members requesting/requiring management by an SCP should be enrolled in care management.

With the listing of an in-plan specialist as SCP, the specialist practitioner is authorized to provide and refer for health care services in the manner of the primary care practitioner, providing the care is relevant to the expertise of the specialist.

In order to assure appropriate coordination of care, the SCP or specialist granted a standing referral shall provide the primary care practitioner or treating practitioner with regular reports on the care provided to the member.

For a specialist to continue to coordinate care, an in-plan SCP must remain actively listed with The Plan or the continuation of a standing referral, the primary care practitioner is required to request an extension of the standing referral every year and to provide updated reports and treatment plans to support medical appropriateness.

Medicaid enrollees must have access to certified pediatric or family nurse practitioners and certified nurse midwives and may designate them as their primary care practitioner.

Specialist and standing referrals are subject to the Timeliness of UM Decisions and Notification Policy.
Member Health and Wellness Promotion

The Health Plan offers an array of primary preventive health interventions to help decrease the incidence or progression of illness and chronic disease. We engage the member in wellness and health promotion activities, such as education, physical activity and health screenings, to encourage a healthy lifestyle.

The Health Plan provides and promotes a health risk assessment (HRA), wellness information, clinical guidelines and other tools on our member website. These initiatives serve to educate and promote change regarding nutrition, exercise, stress management, tobacco cessation, alcohol use, mental health, driving safely and care of hypertension, diabetes, and hyperlipidemia.

Personal Health Risk Assessment (HRA)

The Health Plan attempts to complete an HRA on every Mountain Health Trust and Medicare Advantage member upon enrollment. HRAs are also conducted on members enrolled in complex case management, care management and disease management programs. Re-assessment is ongoing and member specific. Members are risk-stratified based on the HRA results and are navigated to the appropriate department at The Health Plan.

All adult members of The Health Plan may take an online HRA. This self-guided tool will provide a care plan and trigger an activity for THP care staff. Members are navigated to the appropriate department at The Health Plan based on the results of the HRA.

The Health Plan member website offers the following member features:

- Health and wellness educational materials may be requested to be mailed
- Health risk assessment
- Interactive health guidelines to help ensure members obtain the recommended preventive services in the time frames indicated
- Information for enrolling in tobacco cessation classes and other resource materials
Ongoing Educational Materials

Topics that The Health Plan offers education on include:

- Nutrition/Healthy Diet
- Healthy Weight
- Healthy Eating
- Smoking and Tobacco Use
- Stress Management
- Exercise/Physical Activity/Fitness
- Alcohol/Substance Misuse
- Preventive Care: Men’s, Women’s, Children, and Family
- Diabetes
- Mental Health
- Pregnancy
- Congestive Heart Failure
- Autism

The Health Plan member education is offered via:

- Telephonic Outreach
- Onsite Classes
- Mailing
- Newsletters
- Emails
- Social Media
Care Navigation

The care navigation program is a service offered to assist in directing individualized care for the member, usually on a short-term basis and intended to be episodic or situational. Care navigators can be registered nurses, licensed practical nurses or medically trained member advocates. The care navigator coordinates resources across the continuum to minimize costs while improving quality of care. Care navigation is a proactive approach that focuses on promotion of health education and member empowerment through self-management. Medical and Behavioral Health issues are addressed to provide the best possible outcomes. Assistance is provided with management of issues with social determinants of health such as housing, food insecurity and lack of safety in the home.

Members are identified according to established care navigation criteria and by clinical analytics, referrals from other areas of Clinical Services (pharmacy, prior authorization, hospital review, medical directors, or behavioral health), health risk assessments (Medicare, Medicaid), and episodes of transitional care. Additionally, providers, physicians and associated health professionals and employer groups may contact The Health Plan to request care navigation services by phone at 1.800.624.6961, ext. 7644 or online at healthplan.org. Members and family members can self-refer through the same process.

Care navigators perform a telephonic assessment to determine the member’s needs. A plan of care is established by identifying goals and planning interventions to facilitate these goals. Care navigators may place referrals to other services within the Medical Management Department to assist with goals. Pharmacists, licensed social workers, and other health professionals often assist with medical care navigation. The care navigator functions include, but are not limited to managing admissions, facilitating transitional care alongside a facility’s discharge planners, and assisting with referrals to long term acute care facilities, acute rehabilitation units, skilled nursing facilities, or long-term intermediate care placement. Additionally, coordination and authorization of home health services can be included, such as private duty nursing, hospice services, infusion services, outpatient services and assistance with obtaining DME. Care navigators will assist the member to optimize the home environment whenever possible in order to maximize successful healing and rehabilitation.

A schedule for telephonic follow-up with educational support is established with the care navigator’s contact information provided to the member for interim questions/concerns. Care navigators may also provide their contact information to the member’s providers to assist with coordinating services. Members are discharged from the program, with their permission, once goals are achieved and needs are met.
Triggers for Possible Engagement in Medical Care Navigation

1. Self-referral, practitioner referral, family/caregiver referral, group referral, web referral, Nurse Information Line request, or request with any identified need
2. Identification based on a trigger diagnosis with any identified risk factor (*diagnoses specified in complex case navigation are exempt as these are referred for complex case navigation). Sent in real-time by Medical Management Programs: inpatient, prior authorization, pharmacy, or Clinical Services staff
3. Readmissions within 30 days, identified in real time, by inpatient navigation/internal reporting with focus on those with re-admit for same diagnosis and identifiable risk factors increasing likelihood of further readmissions
4. Clinical analytics. Reports identifying specific at-risk populations based on various defined parameters and individualized criteria, stratified by care need index and predictive scores for targeted intervention
5. Risk identified by governmental HRA or outreach (Medicare/Medicaid) including identification of social necessity gaps
6. Enrollment in a clinical trial
7. Discharge outreach/readmission reduction assessment identified beyond the scope of inpatient navigation
8. Redirection of out-of-network or transitional care
9. High cost, stop loss/reinsurance identified post-service
10. Core Wellness needs identified based on online or external risk assessment data
11. Autism
12. ADHD
13. Suicide or homicide attempt within the past 14 days
14. Overdose/Narcan administration
15. Admission to crisis stabilization unit
16. Members with Substance Use Disorder seeking treatment/admission to a residential program
17. Acute inpatient psychiatric treatment
18. More than $20,000 in behavioral health expenses in one year unless member is served by ACT team
19. Individuals with diagnoses likely to represent chronic pain and need for pain management services
20. Prescription Lock In identified
21. Members diagnosed with complications from COVID-19
Complex Case Navigation

The complex case navigation program is a service that helps case manage individual members, normally on a long-term basis, who are identified as high-risk due to catastrophic illness or injury. Members will receive a comprehensive and intensive level of care management provided by a health care professional. Complex case navigators are registered nurses, supervised by certified case managers. The case management process is dependent upon collaboration between treating physicians/facilities, member/families and the complex case navigator to develop and maintain a patient-specific care plan by coordinating resources that create flexible, quality, cost-effective health care options. The complex case navigator will provide a proactive approach that focuses on promotion of health education and member/caregiver empowerment through self-management. Medical behavioral, functional and social determinant of health needs are addressed to provide the best possible outcomes.

Members are identified by established complex case navigation criteria that are primarily diagnosis-driven and based on catastrophic illness/injury with the potential for high cost utilization. Identification can occur in real time, through a health risk assessment, during the prior authorization/referral process, during the inpatient review process, or by clinical analytics. Referrals can also be made from other areas of Clinical Services (pharmacy, medical directors, disease managers, outreach, or behavioral health). In addition, providers, physicians and associated health professionals, or employer groups may request complex case navigation services by contacting The Health Plan at 1.800.624.6961, ext. 7644, or by visiting healthplan.org. Family members and members can self-refer through the same process.

While enrolling the member in the program, the registered nurse will perform a disease-specific needs assessment over the phone.

A key aspect of the complex case manager’s job is to assess the needs of the member from the holistic point of view, particularly identifying any potential behavioral health needs or gaps in social determinants of health such as housing and food security that must be addressed in order to help the member to achieve any proposed wellness goals. When those needs are identified, the complex care manager will make referrals and assist the member to locate necessary resources in their community.

After the assessment is complete, the complex care manager will develop a comprehensive personalized care plan that identifies and prioritizes goals and any potential barriers. After the care plan is created, associated interventions are formed and implemented with all problems identified. Complex case navigators may place referrals to other services within the Clinical Services Department to assist with goals. Pharmacists, licensed social workers, a clinical psychologist and medical directors often assist with complex medical case navigation. Care plan information is shared with the appropriate medical and behavioral providers, including utilization issues, gaps in care, and care need index scores. Referrals are placed to community resources as needed. The complex nurse navigator serves as the direct contact to coordinate care with all involved providers, resources, the member and family/caregiver as appropriate. The complex nurse navigator provides direction for appropriate utilization of health care resources. A schedule for telephonic follow-up, with educational support, is established with the member. The case navigator’s direct contact information is provided to the member for interim questions/concerns.
Complex case navigator functions include, but are not limited to member assessment, education and the development of personalized goal driven care plans that focus on holistic health promotion and maintenance, self-management skills and improving access to care. The complex nurse navigator is also responsible for supporting medical and behavioral facility admissions when necessary, facilitating transitional care alongside a facility’s discharge planners, and assisting with referrals to step down facilities or a level of care most appropriate to the member’s needs. Services supported by the complex nurse navigator include facility-based care, home health services—private duty nursing, hospice, infusion services and Assertive Community Treatment— as well as outpatient services— intensive outpatient programming for behavioral health, dialysis, specialist care and assistance with obtaining DME. Ensuring that every member has the right care, at the right place at the right time is a core principle of the complex nurse navigator. The complex case navigators are here to support members and providers to ensure that medical and behavioral health benefits are understood, utilized and maximized to provide the best possible options and outcomes to our members.
Medical Complex Case Navigation Criteria

1. Transplant—organ and bone marrow/stem cell; includes evaluations, pending and post transplants
2. Catastrophic neuromuscular diseases such as multiple sclerosis, myasthenia gravis, amyotrophic lateral sclerosis
3. Brain injury in active treatment
4. Cystic fibrosis
5. New spinal cord injury
6. Critical or major burns (1st or 2nd degree burns) covering more than 25% of adult’s body or more than 20% of child’s or 3rd degree burns on more than 10% body surface area or burns involving hands, feet, face, eyes or genitals
7. Immunodeficiency
8. Ventilator cases in home setting
9. Major congenital anomalies – atrial septal defect, valve stenosis and atresia, pulmonary artery stenosis, patient ductus arteriosus, craniofacial deformities, myelocystocele, myelomeningocele (such as spina bifida)
10. Premature birth (extreme) 28 weeks or less
11. Complex cancers in active treatment; with anticipated ongoing high cost care, including myelodysplasia
12. Children with special health care needs (CSHCN)
13. Hemophilia
14. Genetic abnormality with ongoing care, treatment or monitoring
15. Trauma – Complex needs in active treatment
16. Serious and persistent mental illness as evidenced by recurrent non-substance use related psychosis or mania with multiple emergent admissions (more than three admissions for CSU and/or inpatient psychiatric acute care per year)
Social Work Services

The Health Plan’s licensed social workers are available to assist members and their families with social determinants of health that may predispose the member to illness or interfere with obtaining the maximum benefit from their medical plan.

The Health Plan’s social worker(s) coordinate with health care providers/practitioners and other THP department staff to identify members needing community resources. The social work staff assists our members with accessing needed services within the community.

**Services provided by the licensed social worker may include:**

- Providing education on how to access available benefits and resources to address out-of-pocket costs for members with financial difficulties and assisting with applications for assistance.
- Coordinating referrals to available resources such as Meals on Wheels, personal care or passport services, transportation services, waiver services and other appropriate supportive services.
- Giving caregiver support and counseling, as well as emphasizing the importance of caregiver self-care.
- Counseling to support members to develop self-advocacy skills to increase positive medical outcomes and quality of life.
- Assisting with discharge planning from a facility as a part of the transitional care team.
- Providing care navigation, per the set criteria, at the appropriate acuity level.
- Consulting or assisting the nurse navigators with procuring the appropriate community resources.

Providers identifying socio-economic needs of members of The Health Plan may contact the licensed social workers for referral for possible assistance programs or other supportive services at 1.800.624.6961, ext. 7644.
Chronic Disease Navigation Programs

The Health Plan’s chronic disease navigation and health promotion programs are multidisciplinary and continuum-based systems developed to proactively identify populations with, or at risk for, chronic medical conditions. Populations currently being managed include members with diabetes or pre-diabetes, chronic cardiac conditions such as coronary artery disease and chronic heart failure (CHF), and chronic obstructive pulmonary disease (COPD). The Health Plan’s pregnant members are also identified and enrolled in either a low risk health promotion trimester education program or a high-risk perinatal program.

Chronic disease navigation programs support the practitioner-patient relationship and plan of care and emphasize the prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies. The Health Plan programs continuously evaluate clinical, humanistic, and economic outcomes with the goal of improving overall health status. The elements of chronic disease navigation include understanding the course, clinical implications, and trajectory of specific diseases; identifying and targeting patients likely to benefit from intervention; focusing on prevention; and working toward resolution of resource-intense problems.

Program Content

Each navigation program includes condition monitoring that is ongoing and proactive. This allows the member, the practitioner, and the chronic disease navigator to assess how well the condition is being managed. Monitoring is done with regular clinical assessments with surveillance of pharmacological management, lifestyle management, and assessment of the member’s understanding of the condition itself as well as the related co-morbid conditions likely to affect overall health status.

Member adherence to the program’s treatment plan is an integral part of chronic disease navigation. Members are followed to determine their success with self-management, self-monitoring activities, and medication compliance. High-risk members are called at periodic intervals. Detailed questions are asked about the member’s condition and information is gathered regarding health status, treatment plan adherence, functional status, and quality of life. Education is targeted at areas of concern based on the findings from a clinical assessment and functional inventory. Ongoing monitoring by the chronic disease navigator ensures timely intervention when a change in risk status is identified. The frequency of outbound calls to participants by the chronic disease navigator is determined by the severity of symptoms. This may result in daily contact in times of high-risk or concern. When home care is needed in high-risk cases, the chronic disease navigator works with the practitioner and a home care agency to coordinate necessary care and services.

In all instances, chronic disease navigation and health promotion programs must consider other health conditions that directly affect the member’s overall health status. A multidisciplinary approach to chronic disease navigation enables the chronic disease navigator to develop a treatment plan that includes condition monitoring of co-morbid conditions frequently associated with chronic medical conditions such as depression and anxiety.

Because lifestyle issues are strongly linked with chronic disease and high-risk pregnancy, strategies to address current lifestyle and the need to modify behavior is addressed in every program. Whether members need interventions addressing issues such as smoking cessation or weight loss management, the chronic disease navigator can address readiness to change and to provide additional resources to affect needed change.
The Health Plan’s chronic disease navigation and health promotion program elements include:

- Identification of best practice, evidence-based standards of care
- Intervention strategies and targeted outcomes
- Identification of the member and assessment of health status
- Proactive intervention to include the application of appropriate therapies and systematic surveillance of appropriateness of medication, education and counseling about daily self-management, and symptom management
- Tracking of the member’s clinical and functional status over time
- Assessment of effectiveness of treatment and sharing of knowledge gained to achieve optimal member outcomes

Attention to all program elements and improvement in all of these areas will likely lead to improved outcomes for the many who are at risk or who suffer chronic diseases.

Please contact The Health Plan Chronic Disease Navigation Department at 1.330.834.2228 or enroll members online at healthplan.org.
Diabetes Program

The diabetes program is designed to modify risk factors associated with diabetes and pre-diabetes, as well as slow the progression of microvascular and macrovascular complications. This is accomplished by promoting treatment plan compliance through education, counseling, and support. Members with diabetes require long-term, continual health care to maintain appropriate glycemic control and to decrease the risk of long-term complications such as neuropathy, nephropathy, and blindness. Program goals include:

- Glycemic control
- Reduction of risk factors
- Optimization of functional capacity
- Prevention of microvascular and macrovascular complications
- Facilitation and enhancement of the patient/doctor relationship

Program Content

Member identification is conducted by ICD-10 analysis of ambulatory and inpatient claims and inpatient DRG 294 and 295. Diagnosis codes include: E08.xx through E11.xx, E13.xx, and 024.xx. Other methods of identification include health risk screenings and direct referral by the primary care physician and specialist. Member stratification is based on severity of illness and co-morbid conditions.

The diabetes program relies on the population based HEDIS® comprehensive diabetes care measures for outcome analysis. The same measures are also used at the individual member level for those members stratified as high-risk and who participate in The Health Plan’s telephonic diabetes navigation program. Primary attention is given to assisting the member in reaching and maintaining glycemic control. Daily self-blood glucose monitoring and quarterly A1C testing are the criteria used to monitor glycemic control. Additional criteria include lipid monitoring and control, dilated eye exam performance, and monitoring of kidney function.

Population-based chronic disease navigation strategies include the annual eye exam program, as well as appropriate educational mailings throughout the year. The provision of diabetic supplies and glucometers for self-monitoring of blood glucose and other diabetes benefits are important components of the program and are available through participating pharmacies for members with The Health Plan pharmacy benefit.

High-risk, moderate, low and pre-diabetes members receive telephonic chronic disease navigation intervention from a diabetes nurse navigator who provides individualized interventions that include the evaluation of appropriate medication use, education and counseling about self-management, surveillance of symptoms, and consideration of other health conditions based on nationally recognized American Diabetes Association (ADA) guidelines.

Condition monitoring and surveillance are ongoing and proactive. Calls are scheduled at periodic intervals. Detailed questions are asked about the patient’s condition and information is gathered about patient status, treatment plan adherence, functional status, and quality of life. Education is based on the ADA "Standards of Medical Care for Patients with Diabetes Mellitus." Ongoing monitoring by the chronic diabetes navigator ensures timely intervention in the event of a change in
risk status. The frequency of outbound calls to the member is determined by the severity of symptoms. This may result in daily contact in times of high-risk as well as consultations with the physician. When home care is needed, the chronic disease nurse navigator works with the home care agency to coordinate the necessary care and services.

A major component of the diabetes program is the empowerment of the member through education. A variety of topics are addressed in both initial and reinforcement teaching. Patient education materials are provided to each patient throughout the program and are used in the teaching process. A thorough education of the disease process and recognition of symptoms of hyperglycemia and hypoglycemia are included. Each member contact includes a review of medications and medication compliance. Lifestyle issues are addressed through education and include the importance of exercise, diet, proper self-management skills, and when indicated, smoking cessation interventions. Members are also referred to certified diabetes educators and the Ohio Valley pharmacy care network (certified pharmacists in diabetes education), to increase member understanding of the disease process and enhance self-management skills.

A successful diabetes program is dependent on the coordination of health care services. The role of the physician is vital, and this program is intended to complement the medical care each member receives from his/her physician. The goal of The Health Plan is to foster a collegial relationship between the physician and the chronic disease nurse navigator to coordinate the necessary care for the member. Evidence-based guidelines are available and recommended for use by the physician to medically manage their patients with diabetes.

**Adult BMI Chart**

The Adult Body Mass Index (BMI) Chart is available [here](#).
Chronic Cardiac Conditions Programs

The chronic cardiac conditions programs are designed to modify cardiovascular risk factors and slow disease progression for members with heart failure and ischemic heart disease. This is accomplished by promoting treatment plan compliance through education, counseling, and support. Program goals include:

- Reversal or stabilization of symptoms
- Optimization of functional capacity
- Improvement of quality of life
- Reduction in frequency of hospitalization
- Facilitation and enhancement of the patient/doctor relationship

Program Content

Member identification is conducted by ICD-10 analysis of ambulatory and inpatient claims and inpatient DRG 127. Diagnosis codes include: I21.xx, I22.xx, and I24.xx for ischemic heart disease and I50.xx for heart failure. Other methods of member identification include health risk screening and direct referral by the primary care physician or cardiologist. Member stratification is based on severity of illness using New York Heart Association classification.

The chronic heart failure program relies on population-based measures of assessment of left ventricular function, ACE inhibitor use, and hospitalization utilization. The same measures are used at the individual member level for those members stratified as high-risk and who participate in The Health Plan’s telephonic chronic heart failure program. Primary attention is paid to the application of appropriate pharmacological therapies including the use of ACE inhibitors and beta-blockers, enhancement of self-management skills, and systematic surveillance of those with symptomatic heart failure to prevent hospitalization.

The ischemic heart disease program relies on population-based HEDIS® (1) measure of beta blocker usage for six months after a discharge for Acute Myocardial Infarction (AMI). The same measures are used at the individual member level for those members stratified as high-risk and who participate in The Health Plan’s telephonic ischemic heart disease program. Primary attention is paid to the application of appropriate pharmacological therapies, lifestyle modification, enhancement of self-management skills, and systematic surveillance of those with symptomatic ischemic heart disease to prevent hospitalization or acute coronary event.

Population-based chronic disease navigation strategies include targeted educational mailings throughout the year. High-risk members receive telephonic chronic disease navigation intervention from a cardiac nurse navigator who provides individualized interventions that include the evaluation of appropriate medication use, education, and counseling about daily self-management, and member recognition of early signs and symptoms requiring intervention. Enrolled members receive home scales, referrals for nutritional education to address dietary compliance, referrals for home oxygen/respiratory therapy when indicated, and immunizations. Consideration of other health conditions, such as diabetes and chronic obstructive pulmonary disease are included in the management program.
Condition monitoring and surveillance are ongoing and proactive. Calls are scheduled at periodic intervals. Detailed questions are asked about the patient’s condition and information is gathered about patient status, treatment plan adherence, functional status, and quality of life. A specific plan of care is developed based on practice guidelines from the ACC/AHA. Guidelines for the Evaluation and Management of Chronic Failure in the Adult, Guidelines for the Management of STEMI and NSTEMI, and Guidelines for the Management of Stable Ischemic Heart Disease. Ongoing monitoring by the chronic cardiac conditions nurse navigator ensures timely intervention when a change in risk status is identified. The frequency of outbound calls to members by the nurse navigator is determined by the member’s severity of symptoms.

This may result in daily contact in times of high-risk or concern as well as consultations with the physician. When home care is needed, the nurse navigator works with the physician and home care agency to coordinate the necessary care and services.

A major component of the chronic cardiac conditions programs is the empowerment of the member through education. A variety of topics are addressed in both initial and reinforcement teaching. Patient education materials are provided to each patient throughout the program and are used in the teaching process. The warning signs are reviewed with each assessment call along with a review of medications and medication compliance. Lifestyle issues are addressed through education and include the appropriateness of exercise, diet, self-management skills, and when indicated, smoking cessation interventions. Patients are encouraged to keep a record of their daily weight and to notify the physician if they experience a weight gain of two pounds in one day to three pounds in one week.

A successful chronic cardiac conditions program is dependent on the coordination of health care services. The role of the physician is vital, and this program is intended to complement the medical care the member is receiving from his/her physician. The goal of the management program is to foster a collegial relationship between the physician and the nurse care navigator in order to coordinate the necessary and appropriate care for the member. Evidence-based guidelines are available on THP website and recommended for use by the physician to medically manage their patients with chronic heart disease.
Chronic Obstructive Pulmonary Disease Program

The chronic obstructive pulmonary disease program (COPD) 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. Members with COPD require long-term, continual health care to maintain functional status and to help eliminate disease exacerbations. Program goals include:

- Slowing the progression or stabilization of symptoms of COPD
- Optimization of functional capacity
- Improvement in quality of life
- Reduction in frequency of hospitalization
- Facilitation and enhancement of the patient/doctor relationship

Member identification is conducted by ICD-10 analysis of ambulatory and inpatient claims and inpatient DRG 88. Diagnostic codes include: J41.xx, J42.xx, J43.xx, and J44.xx. Other methods of member identification include health risk screening and direct referral by the primary care physician or pulmonologist. Member stratification is based on severity of illness and frequency of hospitalization with exacerbations.

The COPD program relies on population-based measures of hospitalization utilization and emergency services utilization. The same measures are also used at the individual member level for those stratified as high-risk and who participate in The Health Plan’s telephonic COPD management program. Primary attention is given to the evaluation of appropriate medication use, education, and counseling about daily self-management and recognition of early COPD exacerbations.

Population-based chronic disease navigation strategies include targeted educational mailings throughout the year. High-risk members receive telephonic chronic disease navigation intervention from a COPD nurse navigator specialist who provides individualized interventions that include the evaluation of appropriate medication use, education, and counseling about daily self-management and recognition of early signs and symptoms of COPD exacerbations requiring intervention. Enrolled members receive home scales, if needed, smoking cessation interventions, if indicated, referrals for nutritional education, referrals for home oxygen/respiratory therapy, when indicated, pulmonary rehabilitation, and immunizations. The Health Plan employs a smoking cessation member advocate that is certified through the American Lung Association in smoking cessation and instruction. Consideration of other health conditions, such as diabetes and chronic heart failure are included in the management program.

Initial management of acute exacerbations include identification of precipitating factors (e.g. infection, volume overload, pulmonary thromboembolism, environmental changes, or overuse of sedating medication) and tailoring drug therapy according to:

- The degree of reversible bronchospasm
- Prior therapy at a stable baseline
- Recent pharmacotherapy and prior medication toxicity
- Presence of contraindications to specific medications
- Specific therapies indicated by the precipitating cause of the exacerbation
Condition monitoring and surveillance are ongoing and proactive. Calls are scheduled at periodic intervals. Detailed questions are asked about the member’s condition and information is gathered about health status, treatment plan and adherence, functional status, and quality of life. Ongoing monitoring by the COPD nurse navigator ensures timely intervention when a change in risk status is identified. The frequency of outbound calls to participants by the nurse navigator is determined by the member’s severity of symptoms. This may result in daily contact in times of high-risk or concern as well as consultations with the physician. When home care is needed, the nurse navigator will work with the physician and home care agency to coordinate the necessary care and services.

A major component of the COPD program is the empowerment of the member through education. A variety of topics are addressed in both initial and reinforcement teaching. Patient education materials are provided to each patient throughout the program and are used in the teaching process. A thorough education of the disease process and recognition of symptoms are included in the teaching process. These warning signs are reviewed at each assessment call along with a review of medications and medication compliance. Education also includes the appropriateness of exercise, diet, self-management skills, the proper use of metered dose inhalers, and when indicated, smoking cessation interventions.

A successful COPD program is dependent on the coordination of health care services. The role of the physician is vital, and this program is intended to complement the medical care the member is receiving from his/her physician. The goal of the management program is to foster a collegial relationship between the physician and the complex case navigator in order to coordinate the necessary and appropriate care for the member. Evidence-based guidelines are available and recommended for use by the physician to medically manage their patients with COPD.
Perinatal Care Program

The perinatal care program is designed to improve pregnancy outcomes, reduce neonatal hospitalizations, and reduce all costs associated with preterm birth and other complications of pregnancy. This is accomplished by providing perinatal education, promoting safe health behaviors, and enhancing the management of maternity care for women identified at high-risk for premature labor and delivery. Program goals include:

- Reduction in the incidence of preterm births
- Reduction in the incidence of low birth weight babies
- Reduction in the number of neonatal intensive care unit days
- Provision of improved perinatal education, promotion of safe health behaviors, and enhanced management of maternity care for women identified as high-risk for premature labor and delivery

Program Content

Member identification and enrollment is initiated once a pregnant member is identified or a referral is received. Referrals may come from the physician, The Health Plan outreach program, self-referral, and claims data. Physicians are provided a perinatal risk screening tool to fill out and forward to The Health Plan.

The targeted time for enrollment of all members is between 12 to 15 weeks gestation. A telephonic assessment of the clinical and psychosocial status of the member is completed by outreach staff at enrollment and again at week 24. Consideration is given to other health conditions. The assessment tool, along with the perinatal risk screen completed by the physician, is reviewed by the program nurse navigator. The mother-to-be is placed in the appropriate low-risk pregnancy group or the high-risk pregnancy group to be case managed.

A late referral education component is available for those women enrolled after 34 weeks gestation. A partial program is offered for those individuals who decline to enroll in the complete program but who want to receive educational materials.

The identification of low-risk Medicaid pregnant women early in pregnancy is designed with the intent of improving the outcome of the pregnancy. Educating the pregnant woman on healthy lifestyle measures reduces risk factors throughout the pregnancy. The low-risk pregnant woman receives an initial assessment, a second trimester assessment, a third trimester assessment, and postpartum assessment conducted by the Outreach Department. The final call ensures the well-being of mother and child.

All Commercial and Self-Funded member pregnancies identified by claims data are offered participation in the prenatal program. After the initial assessment is completed, the program nurse navigator contacts the member every four to six weeks to follow-up on their status and provide education for uncomplicated pregnancies. High-risk members in these groups are followed per high risk protocol.

High-risk pregnancies are monitored and managed aggressively as early as possible and continuously throughout the pregnancy. This group receives general educational mailings as well as specific educational materials based on assessment findings. All participants receive proactive calls from the perinatal care nurse navigator. The perinatal nurse navigator promotes positive outcomes.
for the pregnancy through individualized interventions. A specific plan of care is developed based on the risk status. Ongoing monitoring by the perinatal care navigators ensures timely intervention in the event of a change in risk status. The frequency of outbound calls to participants by the perinatal nurse navigator is determined by the severity of pregnancy risks and complications. This may result in daily contact in times of high-risk or concern. When home care is needed in high-risk cases, the perinatal nurse navigator works with the physician and home care agency to coordinate the necessary care and services.

A major component of the program is to educate the pregnant woman on proactive and healthy lifestyle measures that reduce risk factors throughout the pregnancy. This is achieved by referring members to educational links on THP’s website or providing mailings of educational materials upon request. Verbal education addressing perinatal care, birth alternatives, newborn care, pregnancy wellness and patient-specific risk factors are completed by the nurse navigator. Lifestyle issues such as illegal drug use and smoking are addressed. Smoking cessation interventions are a major focus for those members who are identified as smokers or recent smokers. ACOG and March of Dimes links are provided on THP’s website.

All identified pregnant members receive an initial mailing to introduce them to the pregnancy program. Smoking cessation is offered telephonically as a major component of the program.

A successful perinatal care program is dependent on the coordination of health care services. The role of the physician is vital, and this program is intended to complement the medical care the member is receiving from her physician. The goal of The Health Plan is to foster a collegial relationship between the physician and the perinatal nurse navigator to coordinate the necessary health care to promote a healthy mother and a healthy baby.
Advance Care Planning

At the beginning of 2016, the Centers for Medicare and Medicaid Services (CMS) established separate payments for Advanced Care Planning (ACP) services provided to Medicare beneficiaries. This provision allows for effective communication between patients and their providers to plan for the member’s future care.

- CPT code 99497 for ACP services provided as part of an Annual Wellness Visit (AWV)

*If the ACP is furnished on the same day, by the same provider, the visit is considered a preventive service. Therefore, the deductible and co-insurance are not applied to the codes.

Provider’s Role:

1. Initiate a conversation with all members of The Health Plan over the age of 18.
2. Promote and support THP members’ advance care planning. Document if the member does or does not have an advance directive. Provide them with educational material to help them understand the importance of such documents.
3. Honor their wishes as outlined by their advance care plan and do not discriminate against any member based on the existence or content of their advance directive.
4. Transfer any member whose advance directive you refuse to follow.

Compliance with advance directive policies is part of The Health Plan’s quality review process. Annual audits will be conducted to ensure compliance.

If the member has signed an advance directive, a copy should be retained in the medical record.

To comply with guidelines, all members of The Health Plan 18 years old or older must have documentation on their chart that advance care planning has been discussed, reviewed, and updated at a minimum of every three years.

State-specific information regarding advance directives and The Health Plan Envelope of Life is available on our corporate website.
Leadership and Committees

CMO and Medical Directors

The CMO and medical directors of The Health Plan provide leadership and direction for all utilization management and quality improvement activities. This team plays an important role in the development of the quality management program and supervises quality improvement plans and initiatives. One of the medical directors serves as chairman for each of the following committees:

- Quality Improvement Committee
- Credentialing Committee
- Medical Directors Oversight Committee
- Physician Advisory Committee
- Transplant and New Technology Committee
- Appeal and Grievance Committees

The medical directors are solely responsible for denials of authorization decisions based on medical necessity. They will communicate with primary care physicians, attending physicians, and specialist reviewers as necessary for case discussions.

Other responsibilities of The Health Plan medical directors include:

- Decision making regarding medical appropriateness of care and services
- Review of ALL appeals
- Physician education regarding practice patterns

One of The Health Plan’s medical directors is available 24 hours a day, seven days a week and can be reached for emergencies via The Health Plan Nurse at 1.866.NURSEHP (1.866.687.7347) or during normal business hours toll-free at 1.800.624.6961, ext. 7644.

Physician Advisory Committee

The physician advisory committee is a collaborative committee established to receive input from the physician community to guide The Health Plan in its decision making related to medical policy affecting coverage and reimbursement for physician services and to discuss issues related to relationships and interactions between and among physicians, their patients, and The Health Plan. These issues may include but are not limited to: (a) improvement of health care and clinical and quality through the establishment of clinical and quality guidelines; (b) improvement of communications, relations, and cooperation between physicians and The Health Plan; and/or (c) matters of a clinical or administrative nature that impact the interaction between physicians and The Health Plan.

In addition, physicians serving the Physician Advisory Committee (PAC) may also serve as specialty reviewers, based on board certification and field of expertise. The PAC functions as a subcommittee of the Medical Directors’ Oversight Committee (MDOC).

Members of the committee shall include a representative sample of specialty areas that may include family practice, behavioral health, internal medicine, obstetrics and gynecology, orthopedics,
pediatrics, surgery and medical sub-specialists. Committee members may be asked to serve consecutive terms.

Meetings may be held as actual onsite meetings at central or regional locations with telecommunications accessibility. PAC members may also review guidelines, InterQual®, and other policy and procedural changes related to his/her expertise via mailings.

**Medical Directors’ Oversight Committee (MDOC)**

The MDOC is comprised of The Health Plan’s CMO, medical directors, and various other department leads in Clinical and Pharmacy Services, Quality Improvement and Population Health. The committee oversees the activities of the PAC and ensures issues are dealt with in a timely and appropriate manner. The key functions of the committee are to provide oversight to programs within clinical services, assist in identifying trends and practice pattern variations and develop and initiate interventions as needed.

**Transplant and New Technology Committee (T&T)**

The T&T Committee is comprised of The Health Plan’s CMO, Medical Directors, and other clinical professionals as the topic dictates, nurses, psychologists, pharmacists, etc. The T&T Committee evaluates new medical technologies and the new application of existing technologies including medical procedures, drugs, devices, and transplants to determine medical efficacy and appropriateness of treatment in standard medical practice.

The T&T Committee is responsible for the development of coverage and review guidelines to assist in determinations of medical appropriateness based on current supporting documentation available at the time of the review or request of a particular technology service. Resources utilized in the committee review process may include:

- Centers for Medicare and Medicaid Services (CMS) coverage policies (national and local)
- Winifred S. Hayes, Inc. independent technology assessments
- Federal and state regulatory agency guidelines and mandates
- Clinical outcome studies and data in peer-reviewed published medical literature
- Positions of nationally recognized health professional societies and colleges
- Managed care organizations
- Technology and research agencies
- Opinions of physicians and practitioners in relevant clinical areas

Periodically, and upon request, the committee will revisit and revise previously rendered review guidelines to establish if changes or updates are needed based on updated information on the technology, procedure, or service. Information for review consideration may be forwarded to the committee via email at ttcommittee@healthplan.org.
Appeal and Grievance Committees

The Appeal and Grievance committees are composed of Clinical, Operations, Benefit Services, Quality, Compliance and other staff as needed. They are line of business specific for The Health Plan’s Commercial, Medicaid and Medicare lines of business. These committees convene when necessary to impartially discuss and decide upon a request to reconsider coverage determinations when the member and/or provider are dissatisfied.

Pharmacy and Therapeutics Committee (P&T)

The Pharmacy and Therapeutics Committee is responsible for the formulation and adoption of policies regarding the appropriate evaluation, selection, procurement, distribution, use, and safety of drug therapies. The committee recommends and assists in the development of programs and policies for participating practitioners in all areas pertaining to drug therapy for The Health Plan membership. The committee’s composition includes physicians, pharmacists, and representation from The Health Plan. The Pharmacy and Therapeutics Committee reports quarterly to the Quality Improvement Committee.
Annual Program Evaluation

The medical management program and the quality management program are evaluated on an annual basis. A written summary is prepared from the evaluation process that includes utilization and quality management activities during the year, achievement of goals, and revisions for the upcoming year.

The annual program evaluation is approved by the Executive Management Team (EMT) and the Quality Improvement Committee.

Forms, Tools and Worksheets

- The Medical Prior Authorization and Notification Form is available [here](#).
- The Molecular Pathology Request Form is available [here](#).
Section 8

Population Health
Population Health Management

The Health Plan has a population health management strategy that identifies and stratifies our enrollment population based on medical conditions, risk factors, and social determinants of health.

Data is reviewed to assist in developing programs to meet the needs of various risk groups and engage both members and providers in improving the overall health of the populations.

The population health management team completes a population assessment by evaluating trends of prevalence and financial burden of medical conditions, both chronic and episodic, utilizing analytical software, claims data, business intelligence reporting and care navigation engagement reporting and outcomes.

The intent of the analysis is to develop specific programs to support the four focus items of population health management:

- Keeping members healthy
- Managing members with emerging risk
- Outcomes across healthcare settings
- Managing multiple chronic conditions

Integration of data for this assessment includes medical and behavioral claims and encounter information, pharmacy claims data, laboratory claims, lab values and results. Additionally, information obtained from health risk assessments is analyzed to identify social determinants of health and barriers to care. Electronic health records may also be available through shared portal access with providers. Other various data points include clinical assessments performed by Clinical Services Department nurse navigators and member outreach as well as vendors who may be providing in-home assessments. Data available through licensed software are also incorporated into the analytical process.

The population assessment is completed to determine:

- Needs across The Health Plan service areas
- Which members should be targeted for various care navigation
- Disease management and social services programs
- Whether the current programs are meeting the needs of the population

Included in the assessment is the review of gaps in care related to evidence-based practice as well as member satisfaction with clinical services programs. Data are reported in aggregate and by product line to facilitate an understanding of similarities and differences in health needs and status according to geographical influences. Additionally, further analysis of specific high-risk groups, such as children with special healthcare needs, members with disabilities, and those with severe and persistent mental illness, is completed to ensure the needs of those members are identified.
Examples of social determinants of health that are identified as barriers to care include:

- Transportation and/or lack of transportation
- Mobility issues
- Food insecurity
- Social isolation

The analysis of this comprehensive assessment is shared internally at The Health Plan as well as with network physicians to support alternative payment relationships, including value-based arrangements.
Provider Analytics Program

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. The Health Plan has developed a provider analytics process that uses CCGroup Marketbasket System™ analytical software to build episodes of care from claims data and tie them to specialty-specific medical conditions most 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 comparative peer-to-peer physician scorecards with provider efficiency and effectiveness scores.

The first step in introducing this comparative analysis is to provide historical data to primary care providers. This is completed via face-to-face meetings with large practice groups or on The Health Plan’s secure provider portal. Reports will provide insight into utilization of services and quality of care measures related to patient care and a comparative peer-to-peer analysis.

Additional information explaining the CCGroup Marketbasket System™ methodology and our Provider Analytics Program is available on the provider portal to assist with understanding the information presented in the reports.
HEDIS®

Healthcare Effectiveness Data & Information Set (HEDIS®)

The HEDIS® audit contains a core set of performance measures that provide information about customer satisfaction, specific health care measures, and structural components that ensure quality of care. Annually, The Health Plan is required to report performance measures set forth by HEDIS, to NCQA, CMS, and BMS.

The HEDIS audit takes place annually between January and June and administrative (claim) data is used when applicable. The Health Plan contracts with an outside vendor to assist with medical record retrieval needed for each of the applicable performance measures. A representative from our vendor may contact the office for chart retrieval. There may be an instance that our nurse(s) may need to visit the office and every effort will be made to coordinate the onsite visit to accommodate the provider and office staff.

To support performance measurement, the Population Health unit produces care gap reports to identify members with gaps in care according to HEDIS quality measures specifications. The Health Plan provider engagement representatives can distribute these gap reports to primary care physicians. Gap reports are run monthly based on a proactive review of members’ claim history. Gap reports can be run by TIN, PCP, or quality measure.

Appropriate coding by measure is outlined in the HEDIS 2020 Coding Guide. The HEDIS coding guide is updated annually and is available here, on the THP corporate website, or by request from your THP provider engagement representative.

In addition to utilizing care gap reports and the appropriate HEDIS codes for services rendered, providers can submit clinical documentation for HEDIS measures via fax to the Population Health team at 1.304.433.8208 or by contacting your provider engagement representative.
Dilated Fundus Exam

The population health team requests that our eye care physicians complete and submit the form below upon the completion of all diabetic eye exams. The completed form provides supporting documentation of the examination results to meet the Comprehensive Diabetes Care quality measure. Forms can be submitted with your claim or to the population health team via fax at 1.304.433.8208.

The Dilated Fundus Examination Form can be found here.
Introduction

The Health Plan Quality Management Program consists of quality improvement projects, and the collection and analysis of data to identify and track quality of care issues or concerns. Interventions are based on recognized industry standards, and the outcome of projects is objectively measured.

Goals and Objectives

1. Demonstrate compliance with external Quality Management regulators and programs
   - The National Committee for Quality Assurance (NCQA)
   - Centers for Medicare and Medicaid Services (CMS)
   - Qlarant - External Review Organization for WV DHHR
   - West Virginia and Ohio Departments of Insurance

2. Establish standards and processes for measuring and improving the quality of care and services provided to members
   - Clinical Care Indicators
     - Medical/Surgical Variance Investigation
     - Behavioral Health Variance Investigation
     - Medicare and Medicaid / CMS Driven Investigations
       - Never Events (NE)
       - Hospital-Acquired Conditions (HAC)
       - Health Care-Associated Conditions (HCAC)
   - Customer Satisfaction Indicators
     - Member Complaint Investigation
     - Physician Change Report Reviews
   - Care and Service Indicators
     - Clinical Practice Guidelines
     - Standards for Patient Records and Access to Care and Services
       - Medical Record Audit
   - Quality Management document annual review and revision
     - Quality Management Evaluation
     - Quality Management Program
     - Quality Management Work Plan—The work plan is an annual document that designates each department’s quality management priorities for the year and tracks progress towards meeting these goals. The work plan provides detail on the organization’s identified priorities and describes the activities undertaken to address the quality and safety of clinical care and members’ experience. The Health Plan utilizes the work plan as a method for interdepartmental communication.
     - Quality Management Policies and Procedures

3. Utilize a multi-disciplinary approach to identify areas where improvement is needed
   - Implement and monitor corrective action plans
   - Collaborate with nursing, medical directors, and pharmacy
   - Demonstrate improvement in the quality of medical care and services provided to members as a result of quality management initiatives
Quality of Clinical Care Indicators

The Quality Management Department monitors quality of care concerns centered on evidence-based guidelines. A Nurse Quality Coordinator performs a root cause analysis on each quality of care concern. If the concern is found to be valid, it is forwarded to the Program Integrity Team to determine reimbursement.

The guidelines used can be found at:
- Agency for Healthcare Research and Quality (AHRQ) for PSI 90 Patient Safety Indicators
- National Healthcare Safety Network (NHSN) for healthcare-associated infections
- National Quality Forum (NQF) for serious reportable events

Customer Satisfaction Quality Indicators

The Health Plan investigates and tracks every complaint, grievance, or report of member dissatisfaction. Member complaints, grievances, and/or dissatisfactions are registered with the Customer Service Department or the Quality Management Department.

Indicators of dissatisfaction include:
- Quality of Care
- Access
- Attitude/Service
- Billing/Financial Service by The Health Plan
- Quality of practitioner office site
Review Process for Clinical and Customer Service Quality Indicators

Anyone within The Health Plan organization can identify a customer satisfaction or quality indicator. When any of these indicators are identified, the potential issue is forwarded to the Quality Management Department. A Nurse Quality Coordinator performs a case analysis on the potential issue and obtains medical records to review. A letter of inquiry may be sent to the facility or practitioner, requesting review or clarification of an issue. The letter may include a request for a written analysis or opportunities for improvement established by the facility or practitioner based on the complaint. The Health Plan is dedicated to ensuring that all Federal and State Laws, rules, and regulations are compiled in a timely and effective manner, including The Center for Medicare and Medicaid Services (CMS), The Bureau for Medical Services (BMS) and The Department of Insurance.

* If The Health Plan decides that a practitioner is practicing medicine in a manner that is not keeping with reasonable and prevailing standards of care, a corrective action plan may be requested. If the Quality Improvement Committee (QIC) determines that corrective action is needed, the practitioner will be notified in writing. Corrective measures may vary according to the situation and might include any or all of the following:

- A written warning to the practitioner
- Discussion with the practitioner
- Placing the practitioner under a focused review per medical record or claim data reviews
- Requiring the practitioner to enter into a preceptor relationship with another practitioner
- Requiring the practitioner to complete continuing medical education specific to the treatment, procedure or service in question
- Setting limitations on the practitioner’s privileges or authority to perform specific procedures
Continuity and Coordination of Care

The Health Plan strives to support and enhance the partnership of members and primary care practitioners, to ensure continuity and coordination of care, and member understanding of and participation in their care. All practitioners/providers involved in a member's care must share clinical information with each other and the member in a timely fashion. Most referrals to specialty practitioners or other practitioners/providers must originate with the PCP. Treatment plans should specify an adequate number of direct access visits to specialty practitioners to accommodate the treatment plan’s implementation. Members are afforded direct access to behavioral health practitioners/providers. All referral notifications will include a reminder to all parties to share clinical information in a timely fashion. The Health Plan’s policy regarding continuity and coordination of care states that:

- The primary care practitioner (PCP) bears primary responsibility for coordinating the member’s overall health care in a manner consistent with the member's own goals and preferences. Most referrals to specialty practitioners or other practitioners/providers must originate with the PCP. Treatment plans should specify an adequate number of direct access visits to specialty practitioners to accommodate the implementation of the treatment plan. Members are afforded direct access to behavioral health practitioners/providers. All referral notifications will include a reminder to all parties to share clinical information in a timely fashion. (Refer also to CL-24).

- Practitioners/providers must document member input in all treatment plans submitted for authorization; Clinical Services/Behavioral Health Services nurse navigators will review treatment plans for such documentation before approving requested services.

- When required, nurse navigators will educate members regarding their rights and responsibilities to provide input to practitioners/providers as to their care preferences, and document such education appropriately.

Nurse navigators, will, where appropriate, advise members and practitioners/providers of available training in self-care, health promotion, etc. This advice should include information about non-covered community resources, as well as, The Health Plan coverage for such services as dietary consults, smoking cessation programs, certified diabetic education, home health nurse educators, wound or ostomy care teaching, home infusion services, etc. and are documented.

- The Health Plan does not prohibit a health care professional from advising and advocating on behalf of a member.

- Health care practitioners should provide information about the findings, diagnoses, and treatment options regardless of coverage, so the member has the opportunity to decide among all relevant treatment options.

- The member should be given information about the risks, benefits, and consequences of treatment or non-treatment. They should be provided a choice to refuse treatment and discuss their preferences about failure treatment decisions.

- Nurse navigators will periodically review treatment plans with their members to ascertain progress and compliance. These reviews will be shared with the primary care practitioner, and updated plans requested where appropriate. This process and outcomes are documented.
Standards for Access to Care and Services

Appointment Accessibility Standards for PCPs

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Accessibility Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Routine Non-Urgent/ Preventive Care</strong> (well exams, annual physicals, routine screenings, preventive care, blood pressure checks, wound checks, etc.)</td>
<td>Within 14 calendar days (exceptions permitted at specific times when PCP capacity is temporarily limited)</td>
</tr>
<tr>
<td><strong>Urgent Care</strong> (sprains/strains, minor burns, etc.) If not treated, it could result in a more intense level of treatment.</td>
<td>Within 48 Hours (2 days)</td>
</tr>
<tr>
<td><strong>Not Urgent/Sick Care</strong> (symptomatic care for cold/ flu, sore throat, etc.)</td>
<td>Within 48 Hours (2 days)</td>
</tr>
<tr>
<td><strong>Emergent Care</strong> (requires immediate evaluation &amp; treatment. May be sent to ER for chest pain/heart attack, paralysis/stroke, etc.)</td>
<td>Immediately (same day) or send to ER or call 911 seven days a week</td>
</tr>
<tr>
<td><strong>Pediatric Urgent Care</strong></td>
<td>Same day</td>
</tr>
<tr>
<td><strong>Physical Exams</strong></td>
<td>Scheduled within 180 calendar days</td>
</tr>
<tr>
<td><strong>Preventive/EPSDT Services</strong></td>
<td>Scheduled per EPSDT guidelines and the EPSDT Periodicity Schedule within 30 days</td>
</tr>
</tbody>
</table>

*In-office waiting for appointments must not exceed one hour from the scheduled appointment time.

**After Hours Accessibility**

**After Hours/Week-Ends/Holiday Care Accessibility** – Primary care physician/practitioner or a designated covering practitioner should be available to The Health Plan members within one hour of their leaving a message or contacting the answering service.

**Prenatal Care Accessibility**

**Appointment Accessibility Standards For OB/GYN** – An initial prenatal care visit must be scheduled within 14 calendar days of the date when the woman is found to be pregnant. First and second-trimester visits must be scheduled within seven days of the request. Third-trimester visits must be scheduled within three calendar days of the request. For high-risk pregnancies, appointments must be scheduled within three calendar days of identification as high-risk.

**Specialty Care**

Specialty care providers should provide appointment access within 30 days for new or established patients. Appointment access should be granted sooner for cases where it is medically appropriate or indicated. In-office waiting for appointments must not exceed one hour from the scheduled appointment time.
## Behavioral Health Appointment Accessibility Standards

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial Visit for Routine Care</strong></td>
<td>≤ 10 Working days</td>
</tr>
<tr>
<td><strong>Follow-up Routine Care of an initial visit for a specific condition</strong></td>
<td></td>
</tr>
<tr>
<td>Prescribers</td>
<td>≤ 30 Working days</td>
</tr>
<tr>
<td>Non-prescribers</td>
<td>≤ 20 Working days</td>
</tr>
<tr>
<td><strong>Follow-up after Inpatient Stay</strong></td>
<td>≤ 7 days of discharge</td>
</tr>
<tr>
<td><strong>Urgent Care</strong> - Experiencing worsening of symptoms or new symptoms, that if not treated, could result in a more intense level of treatment.</td>
<td>≤ 48 hours</td>
</tr>
<tr>
<td><strong>Non-Life-Threatening Emergency Care</strong> - Extreme emotional disturbance or behavioral distress, considering harm to self or others, disoriented or out of touch with reality, compromised ability to function, or is otherwise agitated and unable to be calmed.</td>
<td>≤ 6 hours</td>
</tr>
<tr>
<td><strong>Emergency Services</strong></td>
<td>Immediately</td>
</tr>
</tbody>
</table>
Section 10

Behavioral Health
Introduction

The Health Plan strives to ensure the highest quality of care for our members. The Health Plan collaborates with providers/practitioners and members to coordinate care. Our staff works directly with providers/practitioners and members to make available resources known within the provider and community network. Our customer service representatives, nurse navigators, and member advocates are available to assist providers/practitioners and members in obtaining and locating needed services.

The Health Plan’s nurse navigators, also referred to more familiarly as care managers, blend behavioral components (such as motivational interviewing with disease management and other aspects of medical and behavioral health case management) to address the member holistically to provide the best possible outcomes. The care manager may link the member to primary care, specialty care, and behavioral providers/practitioners, as well as address social determinants of health.

Please refer to Section 7 for information that may assist providers in obtaining integrated care for their patients.

The Health Plan’s 24-hour phone number is 1.866.NURSEHP (1.866.687.7347) for any patient needs. This number is answered by nurse navigators who will be able to assist providers/practitioners and members.

Requests for prior authorization of treatment may be submitted telephonically at 1.877.221.9295, electronically through the secure provider portal or by fax to 1.866.616.6255. This fax is secure. Forms are available on The Health Plan website.

Behavioral health admissions may be reported by phone to 1.800.304.9101 24 hours a day/7 day a week (reverts to voicemail after regular business hours).

Information may be emailed to The Health Plan’s secure email at behavioralhealthdocuments@healthplan.org.

Remember, The Health Plan does not require prior authorization for crisis encounters or in plan psychotherapy visits. In plan medication management visits do not require prior authorization for any fully funded or governmental line of business. However, prior authorization may be necessary for these and all other services for employer-funded groups based on individual plan documents. Behavioral health customer service representatives can be reached by calling 1.877.221.9295 for any questions regarding prior authorization requirements.

Refer to Section 5 for behavioral health services, prior authorization requirements, covered services and instructions specific to the West Virginia Medicaid line of business.
Review Criteria

Nationally recognized clinical criteria are utilized to perform reviews for medical appropriateness allowing for consideration of the needs of the individual member, his/her circumstances, medical history, and availability of care and services within The Health Plan network. Input is sought annually, or as needed, in the review of criteria from physicians in the community and those who serve as members of the physician advisory committee. In cases where specific clinical expertise is needed to perform a review, or an appeal is presented, reviews are sent to a contracted URAC or NCQA accredited vendor for specialty medical review services by board-certified physician reviewers with the same or similar background.

InterQual® Review

The Health Plan utilizes Change Healthcare InterQual® criteria as a screening guideline to assist reviewers in determining medical appropriateness of health care services. Any participating provider/practitioner, upon request, may review the specific criteria used in an active clinical review process of a procedure requiring the use of InterQual®. You may call The Health Plan’s Clinical Services Department if you have a general InterQual® question or a question regarding a particular type of care. InterQual® review worksheets are available upon request.

The Health Plan uses InterQual® guidelines for most procedures and services other than for Medicaid groups for whom West Virginia’s Bureau of Medical Services has mandated use of other criteria for specific services (see provider manuals at wvdhhr.org/bms). Refer to The Health Plan’s prior authorization list for lines of business other than Medicaid located at healthplan.org “For Providers,” “Prior Authorization and Referrals.”

Refer to Section 5 to receive Medicaid Behavioral Health specific details.

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.

See authorization request forms for necessary prior authorization information related to behavioral health services located on the provider portal “Forms,” “Behavioral Health Forms”.

Behavioral Health Prior Authorization and Notification Requirements

The Behavioral Health Prior Authorization and Notification Requirements are available here.
Review of Inpatient Treatment, Detoxification, Rehabilitation of Substance Use Disorders and Observation

All inpatient services require admission, concurrent and discharge review by The Health Plan. Only elective admissions may require a preauthorization. Substance Use Disorder residential treatment facilities and Medicaid Crisis Stabilization Units are permitted the first three days of stay without prior authorization in order to maximize the clinical information available at the first authorization review. Intensive Outpatient Programs and Partial Hospitalization Programs are outpatient services that provide a less intensive level of care and The Health Plan amended authorization requirements for these services to allow the first 30 sessions free of authorization for in network providers.

Information may be provided to The Health Plan electronically via the secure provider portal, by fax or telephonically. Faxes should be sent to 1.888.329.8471. For telephonic reviews, call 1.800.304.3101. This number reverts to secure voicemail after normal business hours. This information will be accessed by authorized personnel only.

Forms used in requesting authorization for services are available on The Health Plan’s provider portal under “Forms,” “Behavioral Health Forms.” This information may also be submitted on facility forms. Note that for Medicaid substance use disorder admissions, providers may utilize the form approved for common use by the Bureau for Medical Services or the form developed by The Health Plan is equally acceptable. Both are available as described above.

Reviews are expected on the day of admission with the exceptions described above. If the admission occurs late in the day, on a holiday or weekend, the facility is requested to notify THP immediately and to provide complete clinicals on the next working day. When the admission is approved, the date for concurrent review will be established and conveyed to the provider. This does not apply to admission reviews governed by state law. The Health Plan abides by mandated guidelines.

If the information submitted does not meet review criteria for admission, The Health Plan nurse navigator will forward the clinical information for review to a physician for evaluation. The physician will utilize nationally recognized criteria to provide a clinical review of the case and provide a medical appropriateness determination. A peer to peer discussion may be requested of the facility clinical staff with THP medical directors. The provider/practitioner will be notified when a determination is made. If there is an adverse decision, the provider has an opportunity for reconsideration and further review or the member or their designated representative may appeal as per policy for line of business. A provider may request a peer to peer consultation with a The Health Plan physician at any time.
**Intensive Outpatient Services (IOP)**

Intensive outpatient services are an intermediate level of care in which individuals are typically seen as a group and individually at least three times per week, three hours per day, depending on the structure of the program. IOP for WV Medicaid members must be conducted in programs certified by the Bureau for Medical Services. The first 30 sessions are permitted without authorization.

- Concurrent reviews may be submitted after 30 sessions by fax, phone or electronic transmission.
- If the sessions meet criteria for continued programming, the nurse navigator will continue to allow the course of treatment and inform the facility of the date when the next concurrent review is due. This will continue until discharge.
- Discharge clinicals may be submitted in the same manner as admission and concurrent reviews.
- If the reviews do not meet criteria, the information submitted by the facility will be sent for physician review prior to denial of services.
- IOP services must be preapproved after the initial 30 sessions. Facilities providing IOP to WV Medicaid members must be certified by the Bureau for Medical Services.

**Partial Hospitalization (PH)**

Partial hospitalization is an intermediate level of care for behavioral health conditions. Services are rendered by an accredited program in a treatment setting for behavioral health and/or substance use disorder. The program is an alternative to, or a transition for, traditional inpatient care for members with moderate to severe symptoms. Treatment is an individualized, coordinated, comprehensive, multidisciplinary program. Members participate in this structured program up to five days per week, usually four to five hours per day. Medication management is an integral aspect of partial hospitalization services.

Facilities are expected:

- After the first 30 sessions, authorizations will be issued for the appropriate number of visits. Continuing services must be reviewed concurrently as advised by utilization management. A continued authorization form for these specific services is available.
- If the sessions meet criteria for continued programming, the nurse navigator will continue to allow the course of treatment and inform the facility of the date when the next concurrent review is due. This will continue until discharge.
- Discharge clinical information may be submitted in the same manner as concurrent reviews.
- If the reviews do not meet criteria, the information submitted by the facility will be sent for medical director review to determine medical necessity.
- Facilities providing partial hospitalization to WV Medicaid members must be certified by the WV Bureau for Medical Services.

**Observation**

Observation is a facility-based treatment providing a level of service lower than inpatient, however providing a safe environment to stabilize the member’s condition in an emergency situation. After the observation period has expired, if the member is not ready for discharge, he/she will be transitioned to another level of care. **Please note that observation is not a covered benefit for behavioral health for WV Medicaid members.**
Inpatient Acute Psychiatric and Detoxification Services

Inpatient services are acute psychiatric or detoxification services delivered in a psychiatric, unit of a general hospital or in a free-standing psychiatric facility. The acute care services provided include assessment, individual and group therapies, medication management and attention to medical problems with all care coordinated by the physician. Inpatient hospitalization is usually a short-term stabilization and treatment of an acute episode of behavioral health problems.

Prior authorization of elective admissions is performed to confirm eligibility, benefits, and medical appropriateness of services to be rendered and level of care to be utilized. The process is initiated by the member’s primary care physician (PCP), referring participating specialist or admitting provider/practitioner with the nurse inpatient navigators.

Notification of urgent/emergent admissions by the admitting facility is required at the time of admission. Clinical information is expected within 48 hours of admission. This activity is performed for early discussion of member’s needs as related to the admission, alternative health care services and discharge planning. The Health Plan has a process in place for post stabilization care to ensure continuity of care for members requiring post stabilization medical and behavioral care and services out of plan or when network providers are temporarily not available or accessible.

All out-of-plan and tertiary requests require a referral and prior authorization. Clinical information is reviewed for availability of service within the in-plan network, urgent/emergent situation, or other extenuating circumstances and should be supplied by the behavioral health provider/practitioner.

Concurrent review is the process of continued reassessment of member progress and discharge planning. Any member identified with potential discharge planning needs is referred by behavioral health’s nurse inpatient navigator to the complex case nurse navigator, the care navigator or social worker, as appropriate for early intervention. Concurrent review is performed telephonically, by fax or by electronic transmission. For facility convenience, admission and concurrent or discharge review information forms, as well as a substance use disorder form are available. These reviews involve communication with physicians, hospital UR, social workers, and family members, as necessary. Any time a quality of care issue is identified or suspected, the case is referred to The Health Plan Quality Improvement Department for review.

Inpatient rehabilitation facilities

THP will reimburse for treatment in inpatient rehabilitation facilities such as Substance Use Disorder (SUD) treatment programs, Psychiatric Rehabilitation Treatment Facilities for Medicaid individuals under age 21 (PRTF), for adult psychiatric rehabilitation facilities depending on benefit plan and short-term residential eating disorder programs depending on the terms of a specific benefit plan. All such treatment must meet medical necessity criteria and must be authorized. Admission to a SUD residential program must be authorized within 72 hours and the program must be approved by the Bureau for Medical Services for WV Medicaid members. Please call customer service to obtain information regarding a member’s specific benefit plan at 1.800.624.6961.
Outpatient Prior Authorization and Referral Management

Members are afforded direct access to behavioral health practitioners. No prior authorization is necessary for crisis visits or any urgent or emergent service. Authorization is no longer needed for psychotherapy visits if the member group follows The Health Plan prior authorization list.

Psychological testing may be provided without authorization if the units of service remain within the authorization-free guidelines, depending on the specific benefit plan.

Please refer to the following list of psychological tests that are reimbursable by THP. The chart explains the unit of service, if it is available via telehealth, if prior authorization is required, and any qualifying conditions that must be met.

### Psychological Testing

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>96112</td>
<td>Developmental test administration by qualified professional with interpretation and report</td>
<td>First hour</td>
<td>No</td>
<td>No</td>
<td>Interqual</td>
<td>May only be billed one per event, may only be performed once per year per provider</td>
</tr>
<tr>
<td>96113</td>
<td>Developmental test administration by qualified professional with interpretation and report</td>
<td>Each additional 30 minutes</td>
<td>No</td>
<td>Yes after 6 Units</td>
<td>Interqual</td>
<td>Billed in conjunction with 96112, may not be billed in conjunction with any other psychological testing code other than 96130 and 96131, once per year per provider</td>
</tr>
<tr>
<td>96130</td>
<td>Psychological testing evaluation services by qualified health care professional, including interpretation, report preparation and feedback to patient and caregivers</td>
<td>First hour</td>
<td>No</td>
<td>No</td>
<td>Interqual</td>
<td>May be billed in conjunction with other psychological testing codes, maximum one unit, may only be billed once per year per provider</td>
</tr>
</tbody>
</table>
## Psychological Testing, continued

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>96131</td>
<td>Psychological testing evaluation services by qualified health care professional, including interpretation, report preparation and feedback to patient and caregivers</td>
<td>Each subsequent hour</td>
<td>No</td>
<td>Yes, after one unit</td>
<td>Interqual</td>
<td>May be billed in conjunction with other psychological testing codes, may only be billed once per year per provider</td>
</tr>
<tr>
<td>96132</td>
<td>Neuropsychological testing evaluation services by qualified health care professional, including interpretation, report prep, feedback to patient and caregivers</td>
<td>First hour</td>
<td>No</td>
<td>Yes</td>
<td>Interqual</td>
<td>May be billed in conjunction with 96136 and 96137 once per year per provider, maximum one event</td>
</tr>
<tr>
<td>96133</td>
<td>Neuropsychological testing evaluation services by qualified health care professional, including interpretation, report prep, feedback to patient and caregivers</td>
<td>Each additional hour</td>
<td>No</td>
<td>Yes</td>
<td>Interqual</td>
<td>May be billed in conjunction with 96132, 96136, 96137 once per year per provider</td>
</tr>
<tr>
<td>96136</td>
<td>Psychological or neuropsychological test administration and scoring by qualified health care professional, two or more tests, any method</td>
<td>First 30 minutes</td>
<td>No</td>
<td>No</td>
<td>Interqual</td>
<td>May be billed only once per event, may not be used for administration of screening tools, may be billed in conjunction with any other testing code other than 96112 and 96113 once per year per provider, maximum one event</td>
</tr>
</tbody>
</table>
## Psychological Testing, Cont.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>96137</td>
<td>Psychological or neuropsychological test administration and scoring by qualified health care professional, two or more tests, any method</td>
<td>Each additional 30 minutes</td>
<td>No</td>
<td>Yes after 6 units</td>
<td>Interqual</td>
<td>Billed in conjunction with 96136, may be billed in conjunction with any other psychological testing code except 96112 and 96113, may not be used for administration of screening tools, once per year per provider</td>
</tr>
<tr>
<td>96146</td>
<td>Psychological or neuropsychological test administration, with single automated instrument via electronic platform, with automated result only</td>
<td>Event</td>
<td>No</td>
<td>No</td>
<td>Interqual</td>
<td>May be billed in conjunction with other psychological testing codes</td>
</tr>
<tr>
<td>96116</td>
<td>Neurobehavioral status exam, administration, face to face time with patient and time interpreting test results and preparing report</td>
<td>Event</td>
<td>No</td>
<td>No</td>
<td>Interqual</td>
<td>One per six months per provider, must be performed by qualified professional</td>
</tr>
</tbody>
</table>

*** Grid is THP policy until development of BMS manual and standards for Medicaid members. Non par providers must obtain prior authorization for all events.  
*** Non par providers must submit authorization request for all services.
Remember that additional services may require prior authorization based on specific plan requirements; some may require prior authorization for all services (i.e., ASO depending on group plan documents).

There may be additional services that will require medical director review. Contact The Health Plan if you have a concern regarding a particular procedure or test.

All out-of-plan and tertiary requests require a referral and prior authorization. Clinical information is reviewed for availability of service within the in-plan network, urgency/emergency of the situation, or other extenuating circumstances. This information should be supplied by the behavioral health provider, PCP or appropriate in-plan specialist (if referring within his/her specialty).

Authorization may be obtained via telephone, fax, website or electronic submission. Copies of all treatment request forms are included in the prior authorization section to assist you in obtaining prior authorization for these services. These forms are available on the secure provider portal. They may also be submitted directly from the website or printed and faxed or mailed in for review. Additional services that require prior authorization include procedures that may have limited coverage under the plan benefit. Also, high cost procedures and new technologies that have specific coverage guidelines should be prior authorized to assure medical appropriateness and compliance with established standard of care guidelines. Please contact The Health Plan Clinical Services Department if you have any concern regarding coverage of any service.

Any referral that does not meet medical appropriateness review by the nurse navigator is referred to a medical director for review determination. The medical director may contact the behavioral health provider for case discussion. Availability of services within the provider network and alternative levels of care for services may be offered as appropriate to the member’s needs.

Services that require a prior authorization are listed on The Health Plan Behavioral Health Services prior authorization list.

Please indicate if your request is emergent so that we may expedite the review. Simply scheduling the test/procedure does not warrant an expedited review. Unless an emergency, scheduling should be done after the service is approved by The Health Plan.

Retroactive reviews for utilization: The Health Plan reserves the right to conduct clinical and utilization management reviews retroactively on a random or targeted basis to ensure that the member met medical necessity criteria for the service in question and to review the quality and appropriateness of the service provided.
Drug Screening and Testing

Please be advised that effective **July 1, 2020**, The Health Plan will deny all breath alcohol testing (procedure code 82075) performed in conjunction with any urine drug screen other than dipstick point of care testing (POCT), billed with procedure code 80305. Providers using more complex urine drug testing such as procedure code 80307 or a definitive screen are encouraged to include alcohol as a screened substance.

The Health Plan is making this change in order to ensure the proper utilization of urine drug testing associated with pain management clinics and substance use disorder practitioners and facilities. We would like to remind providers that urine drug testing is most effective when 1) individualized rather than routine, 2) randomized, and 3) conducted in conformance with principles of assessment recommended by the American Society for Addiction Medicine located on the [ASAM website](http://asam.org).

ASAM strongly recommends against routine use of definitive testing. Please review the white paper at the link above. As always, all clinical procedures can be subject to post payment review for medical necessity.

This affects the following lines of business: Commercial, Medicaid, Medicare.

Self-funded groups default to the individual group plan document.

Please direct any questions to the Clinical Services Department at 1.800.624.6961, ext. 7644.
Credentialing and Billing

The Health Plan requires credentialing of all independently licensed behavioral health practitioners operating within a physician’s practice.

Unlicensed personnel may not bill for behavioral health services within a physician’s practice with the exception of supervised psychologists officially approved by the WV Board of Examiners of Psychology. THP will only reimburse supervised psychologists when providing services to our Medicaid members. A supervised psychologist must appear on the web page of the Board of Examiners of Psychologists in WV located here.

Please note that this policy does not apply to physician’s offices within Licensed Behavioral Health Centers. Although the billing procedures described below do not apply to FQHC/RHC, the requirement for credentialing does apply to these agencies.

Please further note that The Health Plan, in conformity with mental health parity rules, does not require prior authorization for clinic-based behavioral health outpatient services. Our authorization list is available on the website under the “For Providers” section.

The Health Plan defaults to CMS policy as interpreted for Medicare for our Commercial plans unless the plan description specifies otherwise. If there is a question regarding this, please contact THP’s Customer Service Department.

Medicare And Most Commercial Plans

The Health Plan conforms to Medicare billing requirements for behavioral health “incident to” services provided by a physician. A very concise summary of these requirements was developed by the National Council for Behavioral Health.

To summarize: if a licensed behavioral health practitioner is employed or contracted by a physician whose scope of practice includes behavioral health, the licensed behavioral health practitioner may bill using the physician’s NPI, with no modifiers. Examples of such rendering practitioners would include: LICSW, Psychologist, LCSW, LGSW, and LPC. Certified Addictions Counselors may also bill under the physician’s NPI if the scope of the service provided is consistent with the counselor’s certification.

As a reminder, any staff person providing services incident to physician’s services must be credentialed with The Health Plan.

To further clarify, if a physician is federally certified as a Medication Assisted Treatment provider, regardless of the physician’s specialty, the physician may have behavioral health practitioners employed or contracted in his office billing incident to the physician’s services only so long as the service being provided relates to the physician’s practice as a MAT provider if the physician’s specialization is not traditionally behavioral health (examples: anesthesiology, internal medicine). A psychiatrist may employ or contract with a behavioral health licensed practitioner to provide a much broader range of services than MAT.

The supervising physician must see the patient initially for assessment and must order the treatment in the patient record as an aspect of the patient’s plan of care. The supervising physician must provide regular reviews of the patient’s status which must be documented in the patient’s record.

Medicare will reimburse “incident to” claims at 100% of the established Medicare rate for the service. Conversely if the licensed behavioral health practitioner is listed on the claim as the rendering...
provider, the claim will reimburse at 85% of the established Medicare rate. All services must be provided at place of service 11, clinic.

**Medicaid**

For information regarding guidelines for billing under the physician or physician extender’s NPI, in conformity with Medicaid requirements, please see Section 5 of this manual.

The Health Plan utilizes the following methodology for applications for credentialing all providers: WV Standardized Credentialing Application found on CAQH or WV Department of Insurance.

Be aware that this will require that the rendering provider have an individual National Provider Identification Number (NPI). A provider may obtain an NPI number on the NPPES website.

Should you have any questions regarding these instructions please feel free to contact our behavioral health provider engagement representative, Seth Shockey at sshockey@healthplan.org or clinical psychologist Sheila Kelly at skelly@healthplan.org.

Providers should be aware that commercial and self-insured policies may vary. Please call our customer services line at 1.877.221.9295 should there be questions regarding these types of policy coverages.

The Health Plan will conduct routine post payment reviews on billings described above. Providers suspected of improper billing may be subject to requests for prior authorization in future and/or may be reported to The Health Plan’s Special Investigations Unit for fraud, waste and abuse. New network providers may be requested to submit planned procedures for prepayment review. All out of network providers are required to submit all procedures for prior authorization.
Annual Program Evaluation

The Health Plan’s utilization management program and the population health driven, care continuum quality management program are evaluated on an annual basis. A written summary is prepared from the evaluation process that includes utilization and quality management activities during the year, achievement of previously identified goals, and revisions of goal statements for the upcoming year.

The annual program evaluation is submitted to, and approved by, the Executive Management Team (EMT) and the Quality Improvement Committee.

Access to Care

To comply with NCQA standards, The Health Plan holds to the following standards for access to care for behavioral health cases:

- Practitioners/providers should provide care within six hours in an emergent, non-life-threatening situation.
- Practitioners/providers should provide care within 48 hours of a request for service when the need is urgent.
- Practitioners/providers should provide a follow-up appointment within seven days of discharge from an inpatient facility.
- Practitioners/providers should provide a new routine office visit within 10 working days of request.
- Prescribing practitioners/providers should provide a follow-up visit within 30 working days of the initial visit.
- Non-prescribing practitioners/providers should provide a follow-up visit within 20 working days of the initial visit.

If the practitioner/provider is not available, the member should be made aware of how to access care. This would apply to after hours and weekend coverage as well as other situations.
Continuity and Coordination of Care

The Health Plan Clinical Services Department advocates continuity and collaboration of care between behavioral health and physical health practitioners/providers. Continuity and coordination is an important aspect in the delivery of quality health care as behavioral and medical conditions interact to affect an individual’s overall health. Information is expected to be exchanged between behavioral and physical health care providers whenever clinically appropriate.

It is the responsibility of the behavioral health practitioner/provider to communicate with the PCP and the PCP to communicate with the behavioral health practitioner/provider. Any information that is shared between practitioners/providers should be maintained in the member’s medical record. If assistance is required to facilitate this exchange of information to ensure care coordination, the Clinical Services Department is available to provide this service.

All federal and state confidentiality laws should be followed. The Health Plan expects that 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. A continuity of care consultation sheet is available on The Health Plan’s secure provider portal for use in facilitating integrated communication.
Behavioral Health Services Forms

The following forms are provided to assist practitioners/providers in requesting services for patients and providing information necessary for continuity and coordination of care. Behavioral health prior authorization and review forms can be transmitted to The Health Plan via the provider secure web portal. These transmissions are received in a secure, restricted fax management queue. The forms listed below are available online at myplan.healthplan.org. Prior authorization requests are also accepted telephonically, electronically, by fax or by email to behavioralhealthdocuments@healthplan.org. Admission, concurrent, and discharge reviews may be called to the nurse inpatient navigator.

- Authorization to Disclose Health Information to PCP
- Admission Review Form
- Concurrent Authorization for ABA/Behavioral Services Form
- Concurrent or Discharge Review Information Form
- Continuity of Care Consultation Form
- Initial Authorization for ABA/Behavioral Services Form
- Psychological Testing Prior Authorization Request Form
- Treatment Continuation Request Form
- Substance Use Disorder Clinical Review Information Form (for non-Medicaid)
- Universal Substance Use Disorder Clinical Review form for Medicaid Member Services
- Prior authorization of Drug Screening (labs)
- Request for ACT Programming – Medicaid Lines of Business only
- Request for ECT/TMS
Telehealth Services

Telehealth services will be paid to behavioral health practitioners/providers when face-to-face services are not feasible. Services that are eligible for telehealth include, but are not limited to, psychotherapy, pharmacological management, diagnostic interview, and neurobehavioral status exam.

Practitioners/providers who are eligible to provide telehealth include, but are not limited to, licensed psychiatrists, psychiatric nurse practitioners, clinical nurse specialists, physician assistants, licensed clinical psychologists, licensed professional counselors and therapists, and clinical social workers.

The Health Plan follows Medicare criteria for telehealth services for all lines of business, with the exception of our WV Medicaid product line. WV BMS policies are followed for the WV Medicaid product line.

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 and the member in a secure manner compliant with federal and state privacy regulations. The telecommunication equipment must be of a quality to 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.

Follow-Up Care after Behavioral Health Admissions

It is extremely important in the care of those with behavioral health conditions, to receive timely follow-up care after discharge from an in-patient stay. The HEDIS® standard is for the member to be seen by a provider/practitioner within seven days of discharge.

The Health Plan is asking for your cooperation and assistance to achieve this important goal.

We would appreciate your facilitating this by:

- Communicating to the hospital discharge planners that follow-up appointments should be scheduled within seven days of discharge.
- Faxing a member’s discharge instructions to our Utilization Management Department at 1.330.830.4397 if you are a facility provider so that we may help to reinforce your discharge plan.
- Communicating to the scheduling staff in your office that it is imperative to schedule appointments for discharging patients within seven days of discharge.
- If you require assistance in this process, please contact our Clinical Services Department for a health care navigator.
Standards and Guidelines of Care

The Health Plan has adopted nationally recognized guidelines to assist our providers/practitioners in providing care to our members. These guidelines address the treatment of depression, the treatment of substance use disorder and guidelines for the diagnosis, evaluation and treatment of ADHD in children and adolescents. Links to these guidelines are posted on The Health Plan website.

These guidelines have been approved by The Health Plan’s Physician Advisory Committee, Medical Director Oversight Committee and the Executive Management Team.

If you have any questions regarding these guidelines, call the Clinical Services Department at 1.800.624.6961, ext. 7644.
Section 11

Pharmacy Services
Introduction

The Health Plan shall promote optimal therapeutic use of pharmaceuticals by encouraging the use of cost effective generic and/or brand drugs in certain therapeutic classes.

The Health Plan has processes in place that explain how members, pharmacists, and physicians determine which medications are covered under the members’ pharmacy benefit, any utilization management requirements and where members can fill medications.

1. The Health Plan publishes a prescription formulary at least annually for all lines of business and posts the formularies on our corporate website. The formulary includes listings of generic, brand and specialty drugs that are available through the pharmacy benefit. The formulary indicates a drug’s copay tier as well as utilization management requirements including prior authorization, step therapy or quantity limit requirements.

In therapeutic classes where The Health Plan has preferred drugs for the treatment of certain diseases, only those drugs are to be used. The Health Plan has utilization management criteria in place to steer members to preferred drugs. The Health Plan publishes the utilization management criteria on the provider portal for our prescribers. In cases where the physician has written a prescription for a drug not on the formulary or for a drug that requires authorization, the dispensing pharmacist will contact the prescriber to change the medication, if possible, to a preferred drug in the class. Therapeutic substitution is only permitted with authorization by the prescriber in the form of a new prescription.

2. Where state pharmaceutical dispensing laws permit, the pharmacy is encouraged to dispense generic forms of prescribed drugs. Only generic drugs that are listed in the FDA “orange book” as being therapeutically equivalent to the innovator product (brand) are required to be dispensed as a generic drug. This is also known as “AB” rated.

The Health Plan pharmaceutical management program allows consideration of medical necessity exceptions for members in obtaining coverage for non-preferred drugs and brand drugs when a generic is available.

3. Prescriptions can be filled at any participating THP pharmacy within the member’s pharmacy network. THP does reserve the right to redirect medications to a specific pharmacy such as a specialty pharmacy for certain medications. Any medication redirection will be communicated to providers via the authorization notification letter.
Clinical Criteria for Pharmaceutical Management Program

The Health Plan’s pharmacy benefit manager utilizes standard criteria to construct the formularies for each line of pharmacy business managed by The Health Plan. The clinical criterion used is taken from relevant clinical literature.

1. Quality Criteria: After FDA approval, each drug is reviewed with regard to its: therapeutic indications, efficacy, dosage frequency, adverse events, therapeutic index, potency, and any compliance factors.

2. Cost Analysis: Each drug is reviewed with regard to its cost in comparison to any formulary alternative in its class. If there is no formulary alternative, the drug is placed on the formulary. If the drug under review has a lower cost alternative, continued review is indicated.

3. Quality vs. Cost: Other cost considerations are examined and include a pharmacoeconomic perspective that evaluates drug therapy cost-effectiveness as it relates to physician visits, patient costs, emergency room visits, laboratory costs, hospitalizations, and sick days.

4. Special Considerations: Criteria is in place for prior authorization of identified drugs, education of physicians and members, drug inclusion in clinical guidelines, and placement of quantity limits on drugs dispensed.

5. Clinical Literature: This is used in every decision to add or exclude pharmaceuticals on the formulary. Clinical evidence shall come from appropriate government agencies, medical associations, national commissions, peer-reviewed journals, and authoritative compendia.

Pharmacy and Therapeutics Committee

The Pharmacy and Therapeutics Committee develops policies and procedures for the utilization management of prescription drugs for The Health Plan. These policies and procedures are designed to enhance the appropriate use of prescriptions in both a clinical and cost-effective manner.

Specialty Pharmacy Program

Specialty drugs are high-cost, high complexity or high touch medications. Specialty drugs are used to treat very specific diseases and require extensive management for safety and effectiveness. Dosages need to be monitored for effect and adjustments might be needed for adequate response to effectively treat the disease.

Specialty drugs require prior authorization to ensure an appropriate candidate for the drug. Additionally, oversight is an integral part of the prior authorization process. Dispensing might be limited to pharmacies with specific skills and distribution programs to ensure proper delivery of these medications. Diseases targeted to receive therapy include, but are not limited to, rheumatoid arthritis, severe chronic psoriasis, multiple sclerosis, hepatitis C, hemophilia, certain cancers, growth deficiency, cystic fibrosis, Crohn’s disease and organ transplant.

Coverage for these agents are provided under the members’ Specialty Pharmacy Benefit. The list of specialty drugs is available on the corporate website under “For Providers” “Prior Authorization and Referrals”
Pain Management Program and Opiate/Opioid Management

The Health Plan limits the acute use of opioid medications for moderate to severe pain from acute injury, medical treatment or surgical procedure for fully insured and employer funded members. The first fill of an opioid medication will be limited to a 5-day supply. This limit is for the first fill of an opioid medication for a member who has no history of opioid usage in the past 130 days.

For those members needing further management of their pain, a prior authorization will be required if:

- The opioid exceeds 80 morphine milligram equivalents
- Is taken for greater than 90 consecutive days
- Is a long acting opioid
- Is being taken with a medication that could cause respiratory depression.

A pharmacist will review the case to evaluate that the opioid is being utilized safely and appropriately. Additionally, the member can be limited to one prescriber and one pharmacy, if needed.

Formulary medications will be preferred over non-formulary medications. Step therapy rules will be applied when reviewing a request for non-formulary medications. Also, dosing and quantities may be limited.
Obtaining a Prescription

Locating a Pharmacy in The Health Plan Network

A THP member may obtain a prescription at any participating THP pharmacy. For the location of a participating pharmacy, call our prescription benefit manager at 1.800.988.2262 or expressscripts.com. The member’s THP ID card must be presented to the pharmacist to allow dispensing of the prescription. The member may be required to pay a copayment which will be collected at the time of service based on the prescription drug plan of the member.

Choosing a Preferred Formulary Drug

Formulary Tier Definitions

- Prescription – Drugs that can only be dispensed upon order (prescription) by a qualified provider of care. Additionally, only drugs which are labeled “Caution: Federal law prohibits dispensing without a prescription” will be considered eligible.
- Generic – A drug available as a chemically and therapeutically equivalent copy of a brand name drug. It is usually available from several manufacturers. Generics must meet federal standards for potency and bioavailability.
- Brand Drug – A prescription item only available from a single source supplier.
- Multi-Source Brand Drugs – Brand name drugs which are manufactured by more than one producer. These agents are usually available as generic equivalents.
- Over-the-Counter Drugs (OTC) – Drugs which are not restricted to prescription-only status. These agents are available for purchase without physician approval and are not covered by THP.
- Home Delivery Service – Certain group benefit designs allow members to receive medications at home via the mail. (See your specific benefits for details).

Pharmaceutical Substitution and Interchange Program

Where state pharmaceutical dispensing laws permit, the pharmacy is encouraged to dispense generic forms of prescribed drugs. Only generic drugs that are listed in the FDA “orange book” as being therapeutically equivalent to the innovator product (brand) are required to be dispensed as a generic drug.

Generic Difference Policy

If a prescription order specifies that a brand name drug must be dispensed when the generic equivalent is available, or the prescription order allows for generic substitution and the member elects to have the prescription filled with a brand name drug instead, the member must pay the brand copayment plus the difference between The Health Plan cost of a brand name and its generic equivalent (i.e., The Health Plan only pays for the generic cost.) Please note non-formulary brand versions of generic drugs require coverage review.
Pharmacy Prior Authorization and Notification Requirements

Pharmacy Pre-Authorization and Notification Requirements are available here.
Formulary

The Health Plan formularies are a listing of prescription medications that are preferred for use. Formulary drugs will be a covered benefit when dispensed at participating pharmacies. Drugs not listed are not covered without written medical statements of necessity by the prescribing physician. Coverage requests may be requested non-urgently or urgently. Requests for non-urgent coverage determinations received after 5 p.m. will be processed the next business day. All requests for coverage determinations will be processed within the applicable state, federal or accrediting agency timeframes.

Multi-source drugs must be dispensed as the generic. Failure to dispense the generic will subject the member to a higher copayment. This higher copay consists of the brand copayment plus the cost difference of the brand drug and generic drug.

Non-Formulary Requests (Exception Policy)

Certain non-formulary medications are eligible for coverage only after a patient-specific approval has been authorized. Patient-specific criteria may include age, gender, and clinical conditions determined by the physician for authorization to be granted for a specific drug. A non-formulary exception request can be made by the member, member’s representative or physician. A Formulary Exception Request Form may be accessed on THP’s secure provider portal “Forms,” “Other Forms” or by contacting Pharmacy Services at 1.800.624.6961, ext. 7914. Exception requests may be requested non-urgently or urgently. Requests for non-urgent exceptions received after 5 p.m. will be processed the next business day. All requests for exceptions will be processed within the applicable state, federal or accrediting agency timeframes.

The Health Plan Pharmacy Service Department is available Monday through Friday 8 a.m. to 5 p.m. and after hours via telephonic auto attendant’s emergency option seven days a week, including holidays. They may be reached at 1.800.624.6961, ext. 7914; fax 304.885.7592.

Requests will be reviewed according to the following criteria:

1. The request for the non-formulary drug is for a condition or medical need not met by existing drugs on The Health Plan formulary.

2. In the physician’s medical judgment, the formulary alternatives have been ineffective in the treatment of the member’s disease or condition (documentation in the member’s clinical record is required).

3. The formulary alternative causes, or is reasonably expected by the prescriber to cause, a harmful or adverse reaction in the member (documentation in the member’s clinical record is required).
Authorization for Coverage

Authorization for coverage consists of rules-based programs for determining whether members qualify for coverage of a requested drug based upon the plan’s predefined benefit criteria. Predefined benefit criteria are based on recommendations of The Health Plan’s Pharmacy and Therapeutics Committee. These rules are periodically reviewed for appropriateness.

Mandatory Generic Policy and Formulary Override Procedure

Pharmacy benefits with a mandatory generic component require that if the prescription item ordered is available from a generic supplier, The Health Plan will cover the maximum allowable cost of the generic. Any additional costs of brand name medication will be the responsibility of the member. This is regardless of any dispense as written indicators (DAW).

Exemption Review Request Procedure

At the time of dispensing, the pharmacist will transmit a claim to The Health Plan claims processor. If the item submitted is available as a generic, the claims processor returns the cost of the prescription in the following manner:

<table>
<thead>
<tr>
<th>Brand submitted</th>
<th>Generic submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>The brand copay is assessed + the difference in the</td>
<td>The generic copayment is assessed, and it is the member’s responsibility to pay at the</td>
</tr>
<tr>
<td>cost of the generic and brand product to arrive at a</td>
<td>time of dispensing</td>
</tr>
<tr>
<td>brand penalty copayment.</td>
<td></td>
</tr>
<tr>
<td>Copay = brand copayment + penalty</td>
<td></td>
</tr>
</tbody>
</table>

Exemptions

The following agents are exempt from mandatory criteria:

Generic drugs not listed in the FDA “orange book” of generic equivalents with an “AB” rating. “AB” rating is defined as therapeutic and generic equivalent.

In cases of defined medical necessity, an exemption to the mandatory generic policy may be authorized. Exemption requests can be called to pharmacy services at 1.800.624.6961, ext. 7914 or faxed to 304.885.7592.

The requests must include:

- Supporting medical literature describing treatment failures of the generics.
- Defined allergic potential to a specific component in a generic NOT found in the brand product. (i.e., fillers, dyes, preservatives)
  - Documented treatment failure of a specific member with supporting clinical assessment and appropriate lab readings.
  - Member refusal to take the generic is not acceptable.
Prior Authorizations

Program Description

The Health Plan Pharmacy Services Department handles customer service calls and coverage review determinations as well as eligibility and prior authorization updates.

Traditional Prior Authorization (TPA)

A program where The Health Plan Pharmacy Services Department adjudicates coverage review determinations as well as authorization updates. This program criteria is developed and conforms to plan coverage conditions for client review and selection and in administering prior authorization protocols. Traditional prior authorization rules require coverage review for all claims presented for a given drug to determine if the member qualifies for coverage for use of the drug, based upon The Health Plan’s pre-defined benefit criteria.

Smart Rules – Automated Prior Authorization Processes at the Point of Sale

Smart rules use sophisticated logic in conjunction with available medical history, drug history, patient reported health information, and medical claims information to determine whether or not a member qualifies for coverage for use of a drug based on the plan’s pre-defined benefit criteria. Smart rules and the pharmacy benefit manager’s system capabilities allow coverage management programs to more efficiently qualify for coverage of those claims that are consistent with the benefit. As a result, smart rules limit reviews for coverage to only those claims where the member’s request is least likely to be appropriate for coverage. Authorizations for coverage smart rule capabilities include qualification or disqualification by medical and prescription history.

Qualification-by-history logic searches the member’s history for the presence of data that will qualify the member for coverage without a requirement for coverage review. Only that member for whom such data is absent requires review for coverage. Disqualification-by-history logic searches the member’s history for the presence of data that will disqualify the member for coverage without a requirement for coverage review. Only those members for whom such data is present require review for coverage.

Authorizing Amount of Coverage

Authorization of amount for coverage is a collection of rules-based programs for determining whether members qualify for coverage of the full amount of drug requested based on the plan’s pre-defined benefit criteria. Authorization of amount for coverage programs use smart rule logic to determine if members qualify for coverage for medications beyond drug-specific thresholds for a quantity, dose and/or duration deemed reasonable for most uses.

Quantity Per Dispensing Event

Quantity per dispensing event rules set dispensing quantity thresholds that reduce client exposure to unnecessary cost, without creating obstacles to access for the vast majority of users. In addition, through coverage review and traditional prior authorization, members can be qualified for additional coverage where warranted by special circumstances and consistent with the intent of the benefit.
Prior Authorization Forms

Prior authorization forms can be found on The Health Plan’s secure provider portal.
Billing
Billing Procedures

1. Electronic claim submission is preferred and encouraged. However, if you choose to submit claims in paper format all paper claims and supporting documentation should be submitted to:
The Health Plan
1110 Main Street
Wheeling, WV 26003

Only original claim forms (red ink) will be accepted. Handwritten claims, copies made from an original claim form, faxed or scanned claims (black ink) will be rejected. As an alternative to paper claims providers may submit claims electronically, free of charge, via The Health Plan’s provider portal, myplan.healthplan.org. Contact your provider engagement representative to learn how.

Claim forms must be completed in their entirety. The efficiency with which the claim form is completed directly affects the efficiency with which the claim is processed for payment. Submission of a clean claim ensures timely and appropriate processing of payment. A clean claim is defined as one that can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim review for medical necessity.

2. The Health Plan requires that all claims are submitted with accurate and current CPT-4, HCPCs, and ICD-10 codes, as appropriate. For each procedure that is listed on the claim a diagnosis code (ICD-10) must support the services (listed in block 24D on the CMS 1500 form) to ensure expeditious and accurate processing of the claim. You must relate the diagnosis(es) listed in block 21 to the individual service lines. You need ONLY to relate diagnosis A, B, C, etc. NOT the ICD-10 code in block 24E. THP encourages the use of category II codes to report performance measures. Use of category II codes will decrease the need for medical record abstraction and chart review.

3. The Health Plan accepts the standard current billing forms: the CMS 1500 (02/12) professional claim form, UB-04 hospital claim form and the ADA dental claim form.

4. When indicating the member ID number on the billing form, the entire number, including the nine-digit ID number and two-digit suffix should be indicated as shown on The Health Plan ID card.

The patient ID number starts with the letter H, the remaining eight digits are numeric. The suffix identifies the family member.

Example:

<table>
<thead>
<tr>
<th>Name</th>
<th>ID Number</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Doe</td>
<td>H01234567-01</td>
<td>Subscriber</td>
</tr>
<tr>
<td>Jane Doe</td>
<td>H01234567-02</td>
<td>Spouse</td>
</tr>
<tr>
<td>Mary Doe</td>
<td>H01234567-03</td>
<td>Child (eldest)</td>
</tr>
</tbody>
</table>

5. Access the NPI registry to locate the NPI number of referring providers and facilities to assist in completing the section related to referring provider on claim forms (blocks 17, 17a and 17b).

6. All services must be billed within 180 days from the date of service.

7. Coordination of benefits (COB) claims (where another carrier has primary responsibility for making payment), must be submitted within 180 days from the date of service or three months...
from the date of the primary carrier’s explanation of benefits (EOB). If you do not receive payment or rejection from the primary carrier and the 180-day time limit is approaching, you must bill The Health Plan before the 180 day deadline, whether or not you have received the EOB from the primary carrier. Refer to Section 14 of this manual for additional COB information.

8. All claims are paid within 30 days from the date of receipt by The Health Plan or as otherwise required by prompt pay requirements. If a clean claim is not paid within the applicable timeframes, appropriate interest will be applied to the claim when it is paid as required by state law, Medicare or Medicaid. For WV Medicaid services, interest will be paid to in-network providers at 18 percent per annum calculated daily for the full period the claim remains unpaid beyond the 30-day clean claims payment deadline.

9. Payment and payment vouchers are available electronically or mailed by request bi-monthly, depending on the line of business. Refer to Section 13 for information regarding electronic remittance.

10. Questions concerning payment or denial must be submitted to The Health Plan the greater of 180 days from the payment/denial date of the claim or 180 days from the date of service. Refer to Section 15 for additional information on claims resubmission procedures.

11. When submitting a refund check to The Health Plan for overpayment (e.g., coordination of benefits, workers’ compensation, subrogation, etc.), include a copy of the payment voucher underlining or circling the claim, and document the reason for the refund. If unsure of the voucher date for the paid claim, you may contact the COB/funds recovery representative at 1.800.624.6961, ext. 7903. Please include detailed information: member name, member ID number, date of service, and the reason for the refund. Refer to Section 15 for more information regarding overpayments and offsetting.

12. The provider should collect applicable deductible, copayments, or co-insurance at the time of service whenever possible. Copayments may not be waived (with the exception of COB) as this is in direct violation of the physician contract with The Health Plan.

13. The Health Plan members are NOT to be billed directly or balance billed for covered services.

14. Procedural manuals will be supplied by The Health Plan to all participating providers, upon request, to assist with The Health Plan guidelines and procedures. The manual can be found on The Health Plan’s corporate website, healthplan.org. Procedural manuals are also available on CD.

15. The Health Plan will NOT reimburse physicians, nor can the member be billed, for the following services:
   - Services not rendered
   - Phone calls (including phone consults)
   - Canceled/missed appointments
   - Making referrals
   - Normal postoperative care
   - Completion of paperwork
• Unnecessary services not indicated by diagnosis
• Mileage
• Stat charges
• Educational services
• Prescriptions
• False information/fraudulent billing
• Never events/avoidable hospital conditions/provider preventable conditions

16. Changes in reimbursement/fee schedules issued by federal and/or state entities will become effective by The Health Plan on the date of notification. Refer to Section 5 for policies regarding changes to Medicaid fee schedules.

17. The Health Plan will comply with Ohio, West Virginia and Medicare prompt pay requirements. Contact The Health Plan at 1.888.816.3096 for self-funded claim and appeal information. Self-funded lines of business default to individual group policy requirements regarding timely filing.
Never Events and Avoidable Hospital Conditions

Never Events

Wrong procedures, or procedures performed on the wrong side, wrong body part, or wrong person, are commonly referred to as “never events.” These never events are not medically necessary as they are not required to diagnose or treat an illness, injury, disease, or its symptoms and are not consistent with generally accepted standards of medical practice. All never events involving a wrong procedure, or a procedure performed on the wrong side, wrong body part, or wrong person are considered not medically necessary, and reimbursement is not permitted. Hospitals generally refrain from billing members for these never events. In the instance where The Health Plan does receive bills for such services, these shall appropriately be denied for lack of medical necessity.

Avoidable Hospital Conditions

Avoidable hospital conditions (a.k.a. hospital-acquired conditions) are conditions “which could reasonably have been prevented through application of evidence-based guidelines.” These conditions are not present when patients are admitted to a hospital but present during the stay. Effective October 1, 2008, the Centers for Medicare and Medicaid Services (CMS) identified the following as preventable hospital acquired conditions:

- Foreign objects retained after surgery
- Air embolism
- Blood incompatibility
- Pressure ulcers stages III and IV
- Falls and trauma
- Catheter-associated urinary tract infection
- Vascular catheter-associated infection and surgical site infection
- Mediastinitis, following coronary artery bypass graft (CABG)
- Manifestations of poor glycemic control
- Surgical site infection following certain orthopedic procedures
- Surgical site infection following bariatric surgery for obesity; and
- Deep vein thrombosis and pulmonary embolism following certain orthopedic procedures.

CMS provided that effective October 1, 2007, hospitals should begin submitting inpatient hospital charges with a present on admission (POA) indicator. POA is defined as a condition that is present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including the emergency department, observation, or outpatient surgery are considered as POA.

The Health Plan reviews and tracks admissions with identifiable never events and avoidable hospital conditions. When it is determined there were additional hospital inpatient days at a participating provider facility, which directly and exclusively resulted from an avoidable hospital condition (not
present on admission), reimbursement for additional inpatient days and/or services may be denied. Further, avoidable hospital conditions and never events shall not be considered in DRG determinations for facilities reimbursed through a DRG methodology. Denials for inpatient hospital days or services which are the result of such circumstances are not billable to the member. These reimbursement denials will not apply to hospital admissions in which the avoidable hospital condition was present on admission, or where another secondary diagnosis is a major complicated/comorbidity (MCC) or complication/comorbidity (CC) in addition to the POA diagnosis, and potentially impacted the avoidable hospital condition.

**Never Events Codes/Hospital-Acquired Conditions/Healthcare Associated Conditions**

<table>
<thead>
<tr>
<th>Codes</th>
<th>Events</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>NA</td>
<td>Preventable</td>
<td>Unintended retention of a foreign object in a patient after surgery or other invasive procedure.</td>
</tr>
<tr>
<td>NB</td>
<td>Serious Preventable</td>
<td>Any death or serious injuries associated with intravascular air embolism that occurs while being cared for in a healthcare setting.</td>
</tr>
<tr>
<td>NC</td>
<td>Serious Preventable</td>
<td>Patient death or serious injury associated with unsafe administration of blood products or the administration of incompatible blood.</td>
</tr>
<tr>
<td>ND</td>
<td>Catheter</td>
<td>Urinary tract infections associated with a catheter.</td>
</tr>
<tr>
<td>ND</td>
<td>Pressure Ulcers</td>
<td>Stage III &amp; IV (decubitus ulcers) acquired after admission/presentation to a health care setting.</td>
</tr>
<tr>
<td>NF</td>
<td>Vascular</td>
<td>Catheter associated infection</td>
</tr>
<tr>
<td>NG</td>
<td>Surgical Site Infection</td>
<td>Mediastinitis within 30 days of coronary artery bypass surgery (CABG).</td>
</tr>
<tr>
<td>NH01</td>
<td>Hospital-Acquired Injury</td>
<td>Falls and fractures</td>
</tr>
<tr>
<td>NH02</td>
<td>Hospital-Acquired Injury</td>
<td>Dislocations</td>
</tr>
<tr>
<td>NH03</td>
<td>Hospital-Acquired Injury</td>
<td>Intracranial injury</td>
</tr>
<tr>
<td>NH04</td>
<td>Hospital-Acquired Injury</td>
<td>Crushing injury</td>
</tr>
<tr>
<td>NH05</td>
<td>Hospital-Acquired Injury</td>
<td>Burns</td>
</tr>
<tr>
<td>NH06</td>
<td>Hospital-Acquired Injury</td>
<td>Other unspecified effects of external causes</td>
</tr>
<tr>
<td>NH07</td>
<td>Hospital-Acquired Death</td>
<td>Postoperative death of a healthy patient (ASA Category 1).</td>
</tr>
<tr>
<td>Codes</td>
<td>Events</td>
<td>Examples</td>
</tr>
<tr>
<td>-------</td>
<td>--------</td>
<td>----------</td>
</tr>
<tr>
<td>NI</td>
<td>Poor Glycemic Control</td>
<td>Diabetic ketoacidosis, non-ketotic hyperosmolar coma, hypoglycemic coma, secondary diabetes with ketoacidosis, secondary diabetes with hyperosmolarity</td>
</tr>
<tr>
<td>NJ</td>
<td>Surgical Site Infection</td>
<td>An infectious or inflammatory reaction due to the implant of an orthopedic device following specific orthopedic procedures (spine, neck, shoulder, elbow) within 365 days.</td>
</tr>
<tr>
<td>NK</td>
<td>Surgical Site Infection</td>
<td>Surgical site infection within 30 days of bariatric surgery for obesity (laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery)</td>
</tr>
<tr>
<td>NL</td>
<td>DVT/PE</td>
<td>DVT or PE following specific orthopedic procedures (total knee/hip replacements), or a DVT that has occurred in an acute hospital and is diagnosed during the hospital stay.</td>
</tr>
<tr>
<td>NM</td>
<td>Surgery/Invasive Procedure NEVER EVENT</td>
<td>A surgery or invasive procedure on the wrong body part.</td>
</tr>
<tr>
<td>NN</td>
<td>Surgery/Invasive Procedure NEVER EVENT</td>
<td>A surgery or invasive procedure on the wrong patient.</td>
</tr>
<tr>
<td>NO</td>
<td>Surgery/Invasive Procedure NEVER EVENT</td>
<td>Wrong surgery/invasive procedure performed on a patient.</td>
</tr>
<tr>
<td>NP</td>
<td>Surgical Site Infection</td>
<td>Surgical site infection following a cardiac implantable electronic device (CIED).</td>
</tr>
<tr>
<td>NQ</td>
<td>Iatrogenic Pneumothorax</td>
<td>Iatrogenic pneumothorax caused by the diagnosis, manner, or treatment of a physician (i.e., inserting venous catheterization).</td>
</tr>
</tbody>
</table>

When any of the above variance codes are identified, a case is generated. Each case is assigned a number, and medical records are ordered to be reviewed. A written evaluation of findings is created, and cases may be reviewed at an interdisciplinary team meeting. If immediate review is necessary, the situation is immediately brought to the attention of the medical director.

Never events, hospital acquired conditions (HACs), and healthcare associated conditions continue to be investigated by The Health Plan. Any of the diagnoses or conditions that are clearly documented as present upon an inpatient admission are not preventable by CMS guidelines.
Electronic Billing – Documentation Submission

To assist with the submission of required documentation for claims adjudication, The Health Plan has a dedicated fax line to submit your documentation. The fax number is 740.699.6163.

In order to assure the required documentation is routed correctly, you must accurately complete The Health Plan fax cover sheet in its entirety. A copy of the Fax Cover Sheet to Support Electronic Claim Submission is available here. Failure to complete the fax cover sheet may result in claim denials. A separate fax cover sheet is required for each document faxed.

Your electronic claim should be marked in the claim note or claim line area with notification stating additional documentation has been faxed. Placing the word FAX in the claim note area will alert our claim reviewers.

You must fax all required documentation within 24 hours of your electronic claims transmission.

Credit Balance Explanation

When a claim is credited against your account, the credit amount can carry over more than one payment. Accordingly, it may be necessary to hold multiple vouchers and post them all at once. In order to assist your accounts receivable representative, here are the basic steps to follow in order to balance out to your deposit when credits have been applied over more than one voucher process.

1. You will need to make sure to evaluate every voucher you receive, even those that are not accompanied by a check or electronic deposit. Vouchers with zero payments often include denials that need to be worked as well as credits applied to current and future paid claims. In the event that a credit balance appears on the voucher you will want to hold the voucher in order to reference the credit activity until the credit has cleared (i.e., until your next voucher with a positive payment amount. This excludes any voucher that only show “Claims in Process,” no payments or credits).

2. In the meantime, please be sure to resubmit corrected claims for all claims denied because the information submitted on the original claim was incorrect. This will avoid a timely filing denial and ensure those claims are promptly reprocessed for payment upon correction.

3. Once the credit has been satisfied and you receive a voucher with a check or an electronic deposit, you can post all of the debits and credits that you have been holding, along with the voucher indicating that you received a check or deposit. After all debits and credits have been posted, you will balance out to the check or deposit.
Example: (see sample vouchers here)
- $319.03 (Plus on to member’s account – this is where your credit begins)
- $132.66 (Payment - Credit off of member’s account)
- $186.37 Outstanding Credit Balance (HOLD Voucher)
- $ 34.90 (Payment - Credit off of member’s account)
- $151.47 Reduced Outstanding Credit Balance (HOLD Voucher)
- $ 67.97 (Payment - Credit off of member’s account)
- $ 83.50 Reduced Outstanding Credit Balance (HOLD Voucher)
- $102.27 (Payment - Credit off of member’s account)
- $167.49 (Payment - Credit off of member’s account)
- $102.27 (Payment - Credit off of member’s account)
- $ 68.28 (Payment - Credit off of member’s account)
$356.81 (As you can see, if you post all the debits and credits together, you will balance out to your check or electronic deposit.)
Notice of Readmissions Review Occurring Within 30 Days

Attention Hospital Providers

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

- A patient was prematurely discharged from the same hospital,
- A facility failed to have proper and adequate discharge planning in place, OR
- If there was a lack of proper coordination between the inpatient and outpatient healthcare teams.

In order for proper payment to occur, providers are required to follow the below guidelines:

- Hospital readmissions within 30 days for the same or similar diagnosis/DRG should be billed and paid as one claim.
- The hospital should combine both stays on one claim and bill with corrected bill type 117.
- Once the corrected claim is received by THP, the 1st admission payment will be reversed, and the corrected claim will be reviewed and processed.
- The corrected claim for the combined stay will process through the DRG calculator/grouper to determine the correct DRG payment for the combined stay. This will assure the correct DRG payment is allowed.

In the absence of information to determine the appropriateness of the readmission, clinically related/potentially preventable readmissions within a seven (7) 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 made/confirmed by an employed medical director of The Health Plan.

Refer to Section 7 for more information on the 30-day hospital readmission review guideline.

Questions regarding claim denials may be directed to the customer service department at 1.800.624.6961.
Introduction

- The Health Plan makes available to their providers various methods of electronic data information (EDI). Access the secure provider portal at myplan.healthplan.org. The provider portal requires a user ID and password for participating health care providers. Helpful information that providers can obtain related to EDI on the provider portal includes:
  - Claim status and submission
  - Member eligibility and benefits
  - Pre-authorization status and submission
  - PCP patient rosters
  - Payment vouchers
- Participating Clearinghouses
- Direct FTP connection
  - Electronic Claims Submissions/837
  - Electronic Payment Vouchers/835/ERA
  - Eligibility HIPAA 270/271 Filing
- Direct Deposit

If you cannot find what you are looking for on our website, please contact:

EDI Support Center
The Health Plan
1110 Main St.
Wheeling, WV 26003
Telephone: 1.877.903.7508
# THP Trading Partner Electronic Submitters

**National Payer ID: 95677**

<table>
<thead>
<tr>
<th>CLEARINGHOUSE</th>
<th>PAYER ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apex EDI</td>
<td>95677</td>
</tr>
<tr>
<td>Alveo/Consult ECP</td>
<td>HPUOV</td>
</tr>
<tr>
<td>Availity</td>
<td>95677</td>
</tr>
<tr>
<td>CPSI/Trubridge</td>
<td>CPSINET</td>
</tr>
<tr>
<td>ClaimLogic</td>
<td>HPUOH</td>
</tr>
<tr>
<td>Claim Source</td>
<td>270704425</td>
</tr>
<tr>
<td>Cortex</td>
<td>CX029</td>
</tr>
<tr>
<td>Emdeon*</td>
<td>34150*</td>
</tr>
<tr>
<td>eSolutions</td>
<td>481213987</td>
</tr>
<tr>
<td>Etactics</td>
<td>UOVOH</td>
</tr>
<tr>
<td>Gateway EDI/TriZetto</td>
<td>00162</td>
</tr>
<tr>
<td>Healthcare IP</td>
<td></td>
</tr>
<tr>
<td>MD Online/Ability</td>
<td>15THP</td>
</tr>
<tr>
<td>MedAssets/ nThrive/ Visient</td>
<td></td>
</tr>
<tr>
<td>MTBC</td>
<td></td>
</tr>
<tr>
<td>Office Ally*</td>
<td>34150*</td>
</tr>
<tr>
<td>Optum*</td>
<td>34150*</td>
</tr>
<tr>
<td>PNC</td>
<td>10060</td>
</tr>
<tr>
<td>Practice Insight</td>
<td>HPUOV</td>
</tr>
<tr>
<td>Quadax</td>
<td>NHPL</td>
</tr>
<tr>
<td>RelayHealth/McKesson</td>
<td>95677</td>
</tr>
<tr>
<td>Rocket System Laboratory</td>
<td></td>
</tr>
<tr>
<td>SSI Group</td>
<td>95677</td>
</tr>
<tr>
<td>ZIRMED/Waystar</td>
<td>10060</td>
</tr>
</tbody>
</table>

*Electronic voucher 835/ERA not available

*Updated 06/2020*
Section 14

Coordination of Benefits (COB)
Coordination of Benefits (COB)

COB is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for medical treatment. COB is designed to eliminate the opportunity for a person to profit from an illness as a result of duplicate group health care coverage. By allowing two or more insurance carriers to work together, the insurance companies can ensure that claims are divided fairly and can avoid paying the same medical bills twice.

Each employer group contracting with The Health Plan has a COB provision in their contract. In accordance with your provider contract, claims for members with another insurance should be submitted to the primary carrier first for payment. The primary plan (plan that pays benefits first) always pays the same benefits it would pay in the absence of any duplicate coverage. The secondary plan (plan that pays benefits second) pays the difference of their allowable amount and whatever the primary plan paid. In accordance with your contract, when The Health Plan is the secondary payer, The Health Plan will consider the balance of covered services not paid by the primary plan, so long as the total payment does not exceed 100 percent of the rates agreed to in your contract. This may mean in some cases that if the primary payment is greater than The Health Plan’s allowable amount, you will receive no additional payment from The Health Plan. Please remember that the patient may not be billed for this balance.

Some lines of business follow NAIC guidelines for COB calculation. In determining the amount to be paid by the secondary plan on a claim, should the plan wish to coordinate benefits, the secondary plan shall calculate the benefits it would have paid on the claim in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed 100 percent of the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

WV Medicaid Members

For members that have primary insurance coverage from a source other than Medicaid, THP will honor coverage and utilization management decisions made by the primary carrier for those services in the primary carrier’s benefits package. If THP is responsible for Medicaid services that are carved out of the primary carrier’s benefit package, THP has utilization management responsibility for those carved out services.
Order of Benefit Determination Rules

Non-Dependent or Dependent: The plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber, or retiree, is the primary plan and the plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent, and primary to the plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, policyholder, subscriber or retiree is the secondary plan and the other plan is the primary plan. Example below:

- **Employee:** The plan covering the person as an employee pays benefits first. (If the patient is our subscriber The Health Plan is primary.)
- **Spouse:** The plan covering that person as a dependent pays benefits second. (If the patient is the spouse of our subscriber, The Health Plan is secondary to the spouse’s insurance.)

Dependent children: The plan covering the parent whose birthday falls earlier in the year is determined before those of the plan of the parent whose birthday falls later in that year. The term “birthday” refers only to the month and day of birth during the calendar year. (If both parents have the same birthday, the benefits of the plan that covered the parent the longest is the primary plan.)

Dependent children of separated or divorced parents: When parents are separated or divorced, the birthday rule applies when the court decree does not designate a specific parent to carry insurance for the child as primary. However, if specific terms of a court decree state that one parent is responsible for the health care expenses of the child, the plan of that parent is primary.

In the absence of a court decree, the following rules apply:

- a. The plan of the parent (with custody) who is the residential parent and legal custodian of the child pays first.
- b. The plan of the spouse of the parent (with custody) who is the residential parent and legal custodian of the child pays next.
- c. The plan of the parent (without custody) who is not the residential parent and legal custodian of the child pays next.
- d. The plan of the spouse of the parent (without custody) who is not the residential parent and legal custodian of the child pays last.

Active/inactive employee: The primary plan is the plan that covers a person as an employee who is neither laid off nor retired, or that employee’s dependent. The secondary plan is the plan that covers that person as a laid-off or retired employee, or the employee’s dependent. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the non-dependent or dependent rule can determine the order of benefits.

Longer/shorter length of coverage: If none of the above rules determines the order of benefits, the plan covering a person longer pays first. The plan covering that person for the shorter time pays second.
Procedures Regarding COB

When a member has another insurance as their primary, please bill that insurance first even if there is a deductible to be met so that the service can be applied to the deductible.

Billing the primary insurance first and attaching the explanation of benefits (EOB) will expedite payment from The Health Plan. All payments indicated on the claim must be supported by an EOB or the claim will be denied. If billing electronically, COB information must be included in the electronic submission.

Each COB claim is reviewed to determine whether The Health Plan is primary. In cases where we are incorrectly billed as the primary payer, the claim will be denied “C,” indicating other insurance primary. The claim will show on your voucher as denied “C” – OTHER INSURANCE PRIMARY. Please bill the primary insurance carrier, then resubmit COB by sending a new claim with the EOB attached to The Health Plan for processing.

Please remember, claims must be submitted to The Health Plan with an EOB within 180 days from the date of service, but no later than three months from the date of the primary carrier’s EOB. Any claims billed to The Health Plan after this time frame will be denied “F” – “TIMELY FILING” and the amount you have billed to The Health Plan must be written off. The member cannot be billed for the balance due. Claims that are submitted after the timely filing limit must have documentation explaining the reason for the delay in submission. This will be reviewed. Please note that self-funded lines of business default to individual group policy requirements regarding timely filing.

Copayments are not to be taken if the primary insurance pays more than The Health Plan copay. The collection of the copay is the responsibility of the individual office. If The Health Plan is primary, the copay may be billed to the member’s secondary coverage if applicable. If a copay is collected at the time of the visit, the provider’s office should refund the copay to the member if the payment voucher shows no copay is due.

If you have double coverage through The Health Plan, the copay, deductible, and/or co-insurance shown on the payment voucher for the primary ID number should be billed to The Health Plan using the secondary ID number. To submit this charge, a HCFA 1500 must be submitted showing the secondary ID number and indicating clearly “billing for copayment.” Also, attach a copy of your voucher showing The Health Plan’s payment under the primary ID number. This amount will be entered on your claim, by The Health Plan’s COB Department, in the COB amount field, and we will process your claim for the copay, co-insurance, or deductible due.

There is often confusion concerning billing procedures for HMO members on Medicare. Therefore, in order to clarify billing procedures for Part B charges for the three types of HMO Medicare members, the billing process to follow when Medicare members present their ID cards is listed.

1. **REGULAR MEDICARE (red, white and blue card):** The Health Plan evaluates primary and secondary coverage with Medicare in accordance with the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982. Please call the COB Department at The Health Plan at 1.800.624.6961, ext. 7903 for clarification of primary responsibility for Medicare members with this ID card.

2. **SECURECARE HMO/SECURECHOICE PPO:** Bill The Health Plan directly for all charges. We are the Medicare carrier for Part A and Part B services.

3. **MEDICARE Supplement:** Bill Medicare first and then bill The Health Plan for any co-insurance or deductibles. (See Medicare crossover notice)
Medicare Crossover Notice

Effective as of Dates-of-Service 8/29/2016

For Medicare Supplement Plans ONLY!

When your patient presents this ID card from The Health Plan, you will no longer have to submit a claim to The Health Plan after Medicare pays.

Medicare will send us your claim information and we will then process for the remaining copayment, co-insurance, or deductible.

As a reminder, this plan will only cover those services that have been allowed or paid by Medicare. If Medicare denies the service, The Health Plan will also deny your claim.

If The Health Plan decides to do Medicare crossover claims for other lines of business, we will notify you at that time.
Medicare Primary

Any physician who has submitted an assigned claim to Medicare has agreed to accept Medicare’s reasonable charge as payment in full for his services. Per Medicare’s Carriers Manual, section 3045.1, the physician is in violation of his signed agreement if he bills or collects from the enrollee and/or the private insurer an amount which, when added to the Medicare benefit received, exceeds the reasonable charge. The Health Plan, as a supplemental insurer, is functioning as a private insurer. Therefore, we will be reimbursing the physician on any services covered by The Health Plan, provided such co-insurance amount does not exceed The Health Plan’s normal fee.

The Health Plan will pay deductibles, copayments, co-insurances, and other member responsibility amounts not paid by the primary carrier so long as the total payment does not exceed the amount The Health Plan would pay as the primary carrier. This process is applied to each individual service.
# Commercial Credit Adjustment Example

## Original Claim Paid as Primary

<table>
<thead>
<tr>
<th>CPT</th>
<th>BILLED</th>
<th>ALLOWED</th>
<th>DISALLOWED</th>
<th>COPAY</th>
<th>COINS</th>
<th>DEDUCTIBLE</th>
<th>MEMB RESP</th>
<th>COB</th>
<th>PAID</th>
<th>REF W/H</th>
<th>NON Ref W/H</th>
<th>ADMIN FEE</th>
<th>DSCNT</th>
<th>ADJ CD</th>
</tr>
</thead>
<tbody>
<tr>
<td>99244</td>
<td>225.00</td>
<td>133.67</td>
<td>91.33</td>
<td>15.00</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>112.74</td>
<td>5.93</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>L</td>
</tr>
<tr>
<td>TOTAL</td>
<td>225.00</td>
<td>133.67</td>
<td>91.33</td>
<td>15.00</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>112.74</td>
<td>5.93</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td></td>
</tr>
</tbody>
</table>

## Credit Adjustment

<table>
<thead>
<tr>
<th>CPT</th>
<th>BILLED</th>
<th>ALLOWED</th>
<th>DISALLOWED</th>
<th>COPAY</th>
<th>COINS</th>
<th>DEDUCTIBLE</th>
<th>MEMB RESP</th>
<th>COB</th>
<th>PAID</th>
<th>REF W/H</th>
<th>NON Ref W/H</th>
<th>ADMIN FEE</th>
<th>DSCNT</th>
<th>ADJ CD</th>
</tr>
</thead>
<tbody>
<tr>
<td>99244</td>
<td>225.00-</td>
<td>133.67-</td>
<td>91.33-</td>
<td>15.00-</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>112.74</td>
<td>5.93-</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>225.00-</td>
<td>133.67-</td>
<td>91.33-</td>
<td>15.00-</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>112.74</td>
<td>5.93-</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>12</td>
</tr>
</tbody>
</table>

## Claim Paid with COB Amount Applied

<table>
<thead>
<tr>
<th>CPT</th>
<th>BILLED</th>
<th>ALLOWED</th>
<th>DISALLOWED</th>
<th>COPAY</th>
<th>COINS</th>
<th>DEDUCTIBLE</th>
<th>MEMB RESP</th>
<th>COB</th>
<th>PAID</th>
<th>REF W/H</th>
<th>NON Ref W/H</th>
<th>ADMIN FEE</th>
<th>DSCNT</th>
<th>ADJ CD</th>
</tr>
</thead>
<tbody>
<tr>
<td>99244</td>
<td>225.00</td>
<td>133.67</td>
<td>91.33</td>
<td>15.00</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>62.62</td>
<td>112.74</td>
<td>5.93</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>L</td>
</tr>
<tr>
<td>COB</td>
<td>62.62</td>
<td>.00</td>
<td>62.62</td>
<td>15.00</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>41.69</td>
<td>5.93</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>225.00</td>
<td>133.67</td>
<td>91.33</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>62.62</td>
<td>71.05</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td></td>
</tr>
</tbody>
</table>

Assuming the allowable amount was the same for The Health Plan as it was for the primary payer.
**Medicare Primary Payment Example**

*The Health Plan Employer Group Coverage Secondary*

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>BILLED AMOUNT</td>
<td>140.00</td>
</tr>
<tr>
<td>MEDICARE ALLOWABLE</td>
<td>81.90</td>
</tr>
<tr>
<td>MEDICARE PAYMENT</td>
<td>65.52</td>
</tr>
<tr>
<td>MEDICARE CO-INSURANCE</td>
<td>16.38</td>
</tr>
<tr>
<td>HEALTH PLAN PAYMENT</td>
<td>16.38</td>
</tr>
</tbody>
</table>

**THE ABOVE ARE EXAMPLES AS THEY WILL APPEAR ON YOUR PAYMENT VOUCHER**

**Medicare Primary Payment as Displayed on Voucher**

<table>
<thead>
<tr>
<th>CPT</th>
<th>BILLED</th>
<th>ALLOWED</th>
<th>DISALLOWED</th>
<th>COPAY</th>
<th>COINS</th>
<th>COB AMT</th>
<th>PAID</th>
<th>REF W/H</th>
<th>NON Ref W/H</th>
<th>ADJ CD</th>
</tr>
</thead>
<tbody>
<tr>
<td>99205</td>
<td>140.00</td>
<td>81.90</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>65.52</td>
<td>16.38</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
</tr>
</tbody>
</table>

(Reduced to Medicare’s Allowable)
Helpful Hints

We have listed a few helpful hints that will help us better serve you and will assist in promoting faster responses and payments.

1. If billing on paper, please send a separate EOB for “EACH” claim submitted to The Health Plan. (Do not attach several claims to one EOB.)

2. When your claim has been denied “C” - OTHER INSURANCE PRIMARY, bill the primary payer for payment/denial. After you have received a response from the primary payer, send a “NEW CLAIM” to The Health Plan with EOB attached for processing. Following this step will expedite your payment.

3. Refer to your voucher for claim status prior to calling The Health Plan. If you still have questions, please have the member’s ID number and date-of-service ready.

4. When sending a refund to The Health Plan, include the member’s name, ID number, date-of-service, claim number, and reason for refund, with documentation in the form of another carrier EOB or voucher. This should be sent to Attention: Funds Recovery, The Health Plan, 1110 Main St, Wheeling, WV 26003.

5. COB filing limitations are calculated from the actual date-of-service, not from the date a claim is received by The Health Plan.

6. After receiving your payment voucher, direct your call to The Health Plan COB Department only for claims denied for COB reasons at 1.800.624.6961, ext. 7903 or 1.740.695.7903. All other calls regarding your voucher are to be directed to the Customer Service Department at 1.800.624.6961.

7. When sending documentation to the attention of the COB Department, please indicate what you are questioning – even if you previously spoke to us about this situation over the phone.

8. When The Health Plan is the secondary payer, all THP guidelines for referrals and pre-authorizations apply.

9. REMINDER: The Health Plan and other health insurance carriers are always primary over Medicaid/Mountain Health Trust (MHT), Medicaid SSI and WV Health Bridge (WVHB).

10. When sending any claim or inquiry to The Health Plan, do not HIGHLIGHT. Please circle, star, or bracket any information you want us to review.
## COB Denial Codes

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td>Other insurance primary</td>
</tr>
<tr>
<td>CB</td>
<td>Explanation of benefits required for paid amount shown.</td>
</tr>
<tr>
<td>CD</td>
<td>Improper primary carrier denial code – primary carrier requesting additional information from provider</td>
</tr>
<tr>
<td>CF</td>
<td>Incorrect EOB attached (e.g., patient name does not appear on EOB or DOS/charges on EOB disagree with claim).</td>
</tr>
<tr>
<td>CG</td>
<td>Require explanation/definition of primary carrier’s denial remarks/reason code</td>
</tr>
<tr>
<td>CHS</td>
<td>Member has enrolled in Hospice.</td>
</tr>
<tr>
<td>CI</td>
<td>Member did not follow primary carrier guidelines; therefore, service is non-covered by The Health Plan.</td>
</tr>
<tr>
<td>CJ</td>
<td>This code/charge did not appear on EOB. Resubmit with EOB that corresponds.</td>
</tr>
<tr>
<td>CK</td>
<td><strong>FOR MOUNTAIN HEALTH TRUST MEMBERS ONLY</strong> Member did not follow primary carrier guidelines; therefore, service is non-covered by Mountain Health Trust.</td>
</tr>
<tr>
<td>COB</td>
<td><strong>Other insurance primary – Medicaid Member</strong></td>
</tr>
<tr>
<td>U</td>
<td>Workers’ compensation primary (for hospital claims)</td>
</tr>
<tr>
<td>UU</td>
<td>Workers’ compensation primary (for ancillary claims)</td>
</tr>
</tbody>
</table>
Section 15

Payment Voucher and Claims
Payment Voucher Introduction

A sample provider voucher is included in this section with the key areas indicated by red numbers. Descriptions of the numbered areas are on the last page of the sample voucher to assist you with reading your payment voucher.

Your payment voucher is divided into three sections:

- Claims paid by line of business
- Claims denied by line of business
- Claims in process
Claim Numbers

Your claim numbers have a meaning.

2020 296 21234

1. The first 4 digits represent the year: 2020
2. The fifth, sixth, and seventh digits represent the Julian date or numeric day of the year. In the example above, Julian day 296 = October 22, 2020
3. The last five digits are for The Health Plan’s in-house record keeping, please disregard these numbers.

Age of Claim Determination

By reviewing the “claims in process” section of your payment voucher, you can determine the payment/denial date and the age of your claims.

The Health Plan is bound by WV prompt pay laws and THP pays clean claims within 30 days of receipt.

Example #1: Establishing your payment/denial date

CLAIM DATE: 2020010 (January 10, 2020)
Add “30” to the claim date = (Julian Date) 010 + (WV prompt pay law) 30 = (Julian Date) 40
Payment/denial date = 40th day of the year or February 9, 2020

Example #2: Establishing the age of your claim

TODAY’S DATE: August 26, 2020 (Julian Date 2020239)
Date of your claim = June 9, 2020 (Julian Date 2020161)
Subtract 2020239 – 2020161 = 78
Your claim is 78 days old

If your claim has been denied or you wish to correct a claim previously paid, you have the greater of 180 days from the claim payment/denial date or 180 days from the date of service to do so.

By following the examples above, you can track your claims from the time they enter The Health Plan’s system to the time you receive your payment or denial.
Claims in Process

Claims that have been received by The Health Plan, but have not been adjudicated, will be listed under the “claims in process” heading of your payment voucher. The Health Plan recommends that providers check their aging reports at 45 days against The Health Plan’s most recent “claims in process” report. This will enable you to track all claims submitted to The Health Plan. If you have an outstanding claim on your aging report that does not appear on your most recent “claims in process,” you should contact The Health Plan’s Customer Service Department at 1.800.624.6961 to verify the status of the claim.

IT IS THE RESPONSIBILITY OF THE INDIVIDUAL PROVIDER TO REVIEW THE VOUCHERS TO ASSURE ALL CLAIMS ARE RECEIVED.

Resubmission of Claims Denied for Documentation

The following procedures have been implemented in order to expedite the processing of claims that are denied for additional documentation when the diagnosis does not support the level of service for Medicare, Commercial and Self-funded lines of business.

Initially, the claim will be reviewed and if it is determined that the diagnosis does not support the level of service, the claim will be denied with the more descriptive denial codes. If the provider agrees with the denial they may resubmit the claim with the appropriate level of service or if the provider disagrees with the denial they may submit appropriate documentation such as office notes, progress notes, etc. to support the level of service originally billed. The provider has the greater of 180 days from the claim payment/denial date or 180 days from the date of service to correct and resubmit the claim or supply additional documentation to support the level of service billed.

Level I:

Once The Health Plan receives the additional documentation to support the level of service, it will be sent to the Claims Department for review by a claims reviewer other than the original claims reviewer. If the documentation supports the level of service, the claim will be reprocessed and, depending on the review date, will show on your next voucher as paid. If the documentation does not support the level of service, the claim will continue to deny. At this time the provider may correct the claim with the appropriate level of service.

Level II:

If the provider feels that the level of service is appropriate, the provider may submit a written request for a third review with additional documentation and it will be sent to a medical director for review. The claim will be paid or denied upon completion of the medical director review. If the medical director agrees with the initial adjudication of the claim, the claim will deny. Send medical director review requests to:

The Health Plan
1110 Main Street
Wheeling, WV 26003
Level III:

If the provider does not agree with the medical director’s decision the provider may submit a written request for an outside independent review of the claim with the appropriate documentation to support the level of service. Send independent review requests to:

The Health Plan
1110 Main Street
Wheeling, WV 26003

The results of this review will be sent back within 30 days from the date of the payment voucher reflecting the medical director’s determination.

Once the decision has been received from the independent reviewer the practitioner/provider will receive written notice of their decision. If it is determined that the documentation supports the claim as submitted the claim will be reprocessed at the level of service billed. If the reviewer determines that the documentation does NOT support the claim as submitted, the provider may resubmit the claim with the appropriate level of service.

If the independent outside reviewer agrees with The Health Plan’s adjudication of the claim, the provider will be responsible for the charges of the independent reviewer, which may vary depending on the hourly rate and the number of claims reviewed. An invoice will be sent to the provider along with the outside reviewer’s decision.

If the independent reviewer rules in favor of the provider, the charges for the review will be the responsibility of The Health Plan. The decision of the independent reviewer is final and the provider will have 30 days from the date of the determination letter to resubmit a corrected claim.

Medicaid Claims Have One Level of Reconsideration/Appeal

If a provider does not agree with the decision made by The Health Plan, they have the right to file a reconsideration. Providers are limited to one level of reconsideration/appeal. A provider has the greater of 180 days from The Health Plan’s denial or 180 days from the date of service to request a reconsideration.
Process to Resubmit a Denied Claim

THP prefers that claims be resubmitted electronically. However, you may resubmit a claim on paper

When resubmitting a claim on paper, please include the following:

- Only a completed original (red ink) CMS 1500 or UB04 claim form will be accepted.
  - Handwritten claims, copies made from an original claim form, faxed or scanned claims (black ink) will be rejected.
- Box 22 on the HCFA 1500 professional claim form must contain one of the following codes:
  - 7 – Replacement of prior claim
  - 8 – Void/cancel prior claim
- Use Bill Type 117 on the UB04 facility claim form to represent a hospital inpatient replacement or corrected claim
- Attach a copy of the payment voucher with the member circled or underlined (The Health Plan’s optical character reader will black out any highlighted text)
- 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

As an alternative to paper claims providers may submit claims electronically, free of charge, via The Health Plan’s [provider portal](#). Contact your provider engagement representative to learn how.

To resubmit a claim electronically through a clearinghouse:

- Use reason code “7” in claim information 2300 Loop Segment CLM05 to indicate replacement of a prior claim
- If you wish to void/cancel a claim, use “8” as the reason code 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 Customer Service at [1.800.624.6961](#) for assistance on why a claim denied and how to resubmit your claim.

Claim Resubmission Form

The Claim Resubmission Form is available [here](#).
## Perpetual Julian Calendar

<table>
<thead>
<tr>
<th>Day</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>32</td>
<td>60</td>
<td>91</td>
<td>121</td>
<td>152</td>
<td>182</td>
<td>213</td>
<td>244</td>
<td>274</td>
<td>305</td>
<td>335</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>33</td>
<td>61</td>
<td>92</td>
<td>122</td>
<td>153</td>
<td>183</td>
<td>214</td>
<td>245</td>
<td>275</td>
<td>306</td>
<td>336</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>34</td>
<td>62</td>
<td>93</td>
<td>123</td>
<td>154</td>
<td>184</td>
<td>215</td>
<td>246</td>
<td>276</td>
<td>307</td>
<td>337</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>35</td>
<td>63</td>
<td>94</td>
<td>124</td>
<td>155</td>
<td>185</td>
<td>216</td>
<td>247</td>
<td>277</td>
<td>308</td>
<td>338</td>
</tr>
<tr>
<td>5</td>
<td>5</td>
<td>36</td>
<td>64</td>
<td>95</td>
<td>125</td>
<td>156</td>
<td>186</td>
<td>217</td>
<td>248</td>
<td>278</td>
<td>309</td>
<td>339</td>
</tr>
<tr>
<td>6</td>
<td>6</td>
<td>37</td>
<td>65</td>
<td>96</td>
<td>126</td>
<td>157</td>
<td>187</td>
<td>218</td>
<td>249</td>
<td>279</td>
<td>310</td>
<td>340</td>
</tr>
<tr>
<td>7</td>
<td>7</td>
<td>38</td>
<td>66</td>
<td>97</td>
<td>127</td>
<td>158</td>
<td>188</td>
<td>219</td>
<td>250</td>
<td>280</td>
<td>311</td>
<td>341</td>
</tr>
<tr>
<td>8</td>
<td>8</td>
<td>39</td>
<td>67</td>
<td>98</td>
<td>128</td>
<td>159</td>
<td>189</td>
<td>220</td>
<td>251</td>
<td>281</td>
<td>312</td>
<td>342</td>
</tr>
<tr>
<td>9</td>
<td>9</td>
<td>40</td>
<td>68</td>
<td>99</td>
<td>129</td>
<td>160</td>
<td>190</td>
<td>221</td>
<td>252</td>
<td>282</td>
<td>313</td>
<td>343</td>
</tr>
<tr>
<td>10</td>
<td>10</td>
<td>41</td>
<td>69</td>
<td>100</td>
<td>130</td>
<td>161</td>
<td>191</td>
<td>222</td>
<td>253</td>
<td>283</td>
<td>314</td>
<td>344</td>
</tr>
<tr>
<td>11</td>
<td>11</td>
<td>42</td>
<td>70</td>
<td>101</td>
<td>131</td>
<td>162</td>
<td>192</td>
<td>223</td>
<td>254</td>
<td>284</td>
<td>315</td>
<td>345</td>
</tr>
<tr>
<td>12</td>
<td>12</td>
<td>43</td>
<td>71</td>
<td>102</td>
<td>132</td>
<td>163</td>
<td>193</td>
<td>224</td>
<td>255</td>
<td>285</td>
<td>316</td>
<td>346</td>
</tr>
<tr>
<td>13</td>
<td>13</td>
<td>44</td>
<td>72</td>
<td>103</td>
<td>133</td>
<td>164</td>
<td>194</td>
<td>225</td>
<td>256</td>
<td>286</td>
<td>317</td>
<td>347</td>
</tr>
<tr>
<td>14</td>
<td>14</td>
<td>45</td>
<td>73</td>
<td>104</td>
<td>134</td>
<td>165</td>
<td>195</td>
<td>226</td>
<td>257</td>
<td>287</td>
<td>318</td>
<td>348</td>
</tr>
<tr>
<td>15</td>
<td>15</td>
<td>46</td>
<td>74</td>
<td>105</td>
<td>135</td>
<td>166</td>
<td>196</td>
<td>227</td>
<td>258</td>
<td>288</td>
<td>319</td>
<td>349</td>
</tr>
<tr>
<td>16</td>
<td>16</td>
<td>47</td>
<td>75</td>
<td>106</td>
<td>136</td>
<td>167</td>
<td>197</td>
<td>228</td>
<td>259</td>
<td>289</td>
<td>320</td>
<td>350</td>
</tr>
<tr>
<td>17</td>
<td>17</td>
<td>48</td>
<td>76</td>
<td>107</td>
<td>137</td>
<td>168</td>
<td>198</td>
<td>229</td>
<td>260</td>
<td>290</td>
<td>321</td>
<td>351</td>
</tr>
<tr>
<td>18</td>
<td>18</td>
<td>49</td>
<td>77</td>
<td>108</td>
<td>138</td>
<td>169</td>
<td>199</td>
<td>230</td>
<td>261</td>
<td>291</td>
<td>322</td>
<td>352</td>
</tr>
<tr>
<td>19</td>
<td>19</td>
<td>50</td>
<td>78</td>
<td>109</td>
<td>139</td>
<td>170</td>
<td>200</td>
<td>231</td>
<td>262</td>
<td>292</td>
<td>323</td>
<td>353</td>
</tr>
<tr>
<td>20</td>
<td>20</td>
<td>51</td>
<td>79</td>
<td>110</td>
<td>140</td>
<td>171</td>
<td>201</td>
<td>232</td>
<td>263</td>
<td>293</td>
<td>324</td>
<td>354</td>
</tr>
<tr>
<td>21</td>
<td>21</td>
<td>52</td>
<td>80</td>
<td>111</td>
<td>141</td>
<td>172</td>
<td>202</td>
<td>233</td>
<td>264</td>
<td>294</td>
<td>325</td>
<td>355</td>
</tr>
<tr>
<td>22</td>
<td>22</td>
<td>53</td>
<td>81</td>
<td>112</td>
<td>142</td>
<td>173</td>
<td>203</td>
<td>234</td>
<td>265</td>
<td>295</td>
<td>326</td>
<td>356</td>
</tr>
<tr>
<td>23</td>
<td>23</td>
<td>54</td>
<td>82</td>
<td>113</td>
<td>143</td>
<td>174</td>
<td>204</td>
<td>235</td>
<td>266</td>
<td>296</td>
<td>327</td>
<td>357</td>
</tr>
<tr>
<td>24</td>
<td>24</td>
<td>55</td>
<td>83</td>
<td>114</td>
<td>144</td>
<td>175</td>
<td>205</td>
<td>236</td>
<td>267</td>
<td>297</td>
<td>328</td>
<td>358</td>
</tr>
<tr>
<td>25</td>
<td>25</td>
<td>56</td>
<td>84</td>
<td>115</td>
<td>145</td>
<td>176</td>
<td>206</td>
<td>237</td>
<td>268</td>
<td>298</td>
<td>329</td>
<td>359</td>
</tr>
<tr>
<td>26</td>
<td>26</td>
<td>57</td>
<td>85</td>
<td>116</td>
<td>146</td>
<td>177</td>
<td>207</td>
<td>238</td>
<td>269</td>
<td>299</td>
<td>330</td>
<td>360</td>
</tr>
<tr>
<td>27</td>
<td>27</td>
<td>58</td>
<td>86</td>
<td>117</td>
<td>147</td>
<td>178</td>
<td>208</td>
<td>239</td>
<td>270</td>
<td>300</td>
<td>331</td>
<td>361</td>
</tr>
<tr>
<td>28</td>
<td>28</td>
<td>59</td>
<td>87</td>
<td>118</td>
<td>148</td>
<td>179</td>
<td>209</td>
<td>240</td>
<td>271</td>
<td>301</td>
<td>332</td>
<td>362</td>
</tr>
<tr>
<td>29</td>
<td>29</td>
<td>*</td>
<td>88</td>
<td>119</td>
<td>149</td>
<td>180</td>
<td>210</td>
<td>241</td>
<td>272</td>
<td>302</td>
<td>333</td>
<td>363</td>
</tr>
<tr>
<td>30</td>
<td>30</td>
<td>89</td>
<td>120</td>
<td>150</td>
<td>181</td>
<td>211</td>
<td>242</td>
<td>273</td>
<td>303</td>
<td>334</td>
<td>364</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>31</td>
<td>90</td>
<td>151</td>
<td>212</td>
<td>243</td>
<td>304</td>
<td>365</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Add an extra day in years divisible by four (2020, 2024, 2028, etc.) for leap year*
Overpayments and Offsetting

An overpayment can be identified by the provider or The Health Plan. If the provider identifies the overpayment, they can either submit a refund check with an explanation of the refund and/or explanation of benefits to The Health Plan or they can call 1.800.624.6961 and request to speak with the Funds Recovery Department 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 as noted in your provider agreement. You will have forty (40) days to notify us of your intent to pay or appeal the overpayment determination. If you have not refunded us within forty (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. Refer to Section 18 Special Investigations Unit in this manual for information on provider self-audits and overpayments.

Payments should be sent to:

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

For Medicaid identified overpayments, please refer to Section 5 of this Manual.
Section 16

Credentialing
Credentialing

The Health Plan is accredited by the National Committee on Quality Assurance (NCQA) and as such is required to comply with quality assurance standards on credentialing. In addition, The Health Plan is required to comply with the states of West Virginia and Ohio, West Virginia Medicaid and CMS credentialing guidelines, as well as other states and regulatory requirements.

The initial credentialing process includes:

- An office site survey of primary care physicians who provide service to West Virginia Medicaid recipients
- In addition to primary care physicians, an office site survey will be performed on obstetrics (OB)/gynecologists (GYN) and designated high-volume specialists who provide service to West Virginia Medicaid recipients
- Medical record review
- Physician application

Copies of:

- Licensure(s)
- Clinical privileges
- DEA registration
- Complete malpractice history
- Board certifications
- Proof of cultural competency training

Upon expiration of any of the above listed credentials, the credentialing department may request copies of the above expired credentials. **It is imperative that we receive this information as quickly as possible.**

**The practitioner has the right to review all information submitted to The Health Plan in support of the credentialing/recredentialing application.**

If you wish to review the information submitted to The Health Plan, in support of the credentialing/recredentialing application, please call the Manager of Credentialing at 1.740.699.6129 to schedule an appointment to come to The Health Plan. You will have access to your credentialing application and primary source verification documents received during the most current credentialing/recredentialing cycle. You will not have access to protected peer review information, references or recommendations.
Recredentialing

The Health Plan recredentials all practitioners, at a minimum within 36 months of the initial credential date.

This recredentialing process includes primary verification of:

- Licensure(s)
- Clinical privileges
- Valid DEA
- Board certification
- Adequate malpractice insurance
- Professional liability claims history
- Reappointment application
- Member complaints and quality of care issues
- Verifying the information contained on the reappointment application
Practitioner’s Credentialing/Recredentialing Rights

The practitioner has the right to correct erroneous information. Any omissions, inconsistencies or erroneous information that is discovered during any of the listed verification processes will require further investigation by the manager of credentialing services. The manager of credentialing services will review the information to determine if it needs to go to the medical director for direction or select a course of action that may include:

- The manager of credentialing will send a written notice to the practitioner along with a copy of the application containing the discrepancy. The letter will state that the provider has 15 calendar days to respond in writing to the request for correction/update. If there is no written response received within the 15-calendar day timespan, a credentialing representative will contact the office via email or phone to ascertain why there has been no response. Once contacted, the practitioner is afforded an additional 15 calendar days to reply. The written explanation must be returned by secure fax at 740.695.7883 or via postal mail to the manager of credentialing, or the credentialing representative listed on the letter, to 1110 Main Street, Wheeling WV, 26003.

If no response is received by the credentialing representative within 15 days of contact, the file will be placed in an inactive file and the practitioner will be notified of this status by letter.

- Once the information is received, the practitioner will be notified via email, fax, or telephone by the manager or a credentialing representative. The information will be taken to the medical director and/or blinded and taken to the credentials committee, along with the explanation from the practitioner, for the committee’s acceptance, acceptance with restrictions, or rejection.

The practitioner has the right, upon request, to be informed of the status of their credentialing or recredentialing application. The information that will be afforded to the practitioner includes: the application is still in process; it is pending to the credentials committee or in review by the medical director awaiting sign-off. The practitioner may request status by contacting The Health Plan credentialing department at 1.740.699.6279 or 1.800.624.6961 ext. 6279 or via e-mail at hpecs@healthplan.org. The practitioner will be contacted by telephone or mail with the response to his/her request for application status. This response will be within five business days of the request.

The practitioner has the right to review all information submitted to The Health Plan in support of the credentialing/recredentialing application.

If you wish to review the information submitted to The Health Plan in support of the credentialing/recredentialing application, please call the manager of credentialing at 740.699.6129 to schedule an appointment to come to The Health Plan. You will have access to your credentialing application and primary source verification documents received during the most current credentialing/recredentialing cycle. You will not have access to protected peer review information, references or recommendations.
**WV practitioners:** The State of West Virginia mandatory credentialing and recredentialing applications are located on the West Virginia Insurance Commissioner’s website. They may also be found on The Council for Affordable Quality Healthcare’s (CAQH) website if you are a member of CAQH.

**OH practitioners:** The Health Care Simplification Act HB125 (ORC 3963.05) requires all Ohio physicians to complete the CAQH form. The Health Plan subscribes to CAQH; therefore, can retrieve the practitioner’s application from the CAQH website. If the practitioner has not yet completed their initial application through CAQH, they may access the application electronically through CAQH.

**OH ancillary providers:** Ancillary applications are located on the Ohio Department of Insurance’s website. If the practitioner is unable to obtain these forms electronically, please contact Provider Relations at 1.800.624.6961 and these forms will be sent to you via secure fax, email, or certified mail.
Office Orientation and Medical Site Survey Form
The Office Orientation and Medical Site Survey Form is available here.

Office Orientation and Behavioral Health Site Survey Form
The Office Orientation and Behavioral Health Site Survey Form is available here.
Standards for Participation

To become a THP provider, a physician must meet the standards of participation as developed by The Health Plan. Practitioners cannot provide medical care to our members until they are fully credentialed.

**A physician must have the following credentials:**

- Drug Enforcement Administration (DEA) registration number if the scope of practice would warrant the physician to have a DEA
- Professional liability – minimum amount of $1 million, any amount below minimum will be reviewed by the Credentials Committee
- Admitting privileges at a participating hospital
- Clear report from the National Data Bank
- Board-certified or board eligible. If not board-certified or board-eligible, the physician must demonstrate appropriate training for specialty listed
- Signed and dated agreement
- Office site survey for primary care physicians (PCP), OB/GYN and those providers designated by the plan as a high-volume specialist who provides service to Medicaid recipients.
- Proof of current medical license(s)
- Sufficient information concerning any malpractice actions.
- NPI number and UPIN or PTAN number
  - The Centers for Medicare and Medicaid (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.
- Completed application
- Proof of cultural competency training

**Practitioners/providers eligible for participation with The Health Plan are:**

- Medical doctor
- Doctor of osteopathy
- Doctor of podiatric medicine
- Doctor of dental surgery
- Doctor of chiropractic medicine
- Audiologist
- Certified nurse practitioner – must submit a copy of their collaborative agreement and/or prescriptive authority (if applicable) with a physician who is a participating practitioner with The Health Plan
- Certified nurse midwife – must have a collaborative agreement with an obstetrician
- Physician assistant – the collaborating physician must be participating with The Health Plan and the PA must submit a copy of the practice agreement with the collaborating physician
- Independent physical therapist
- Optometrist
- Fully licensed psychologist
- Clinical licensed master social worker
• Ambulance provider
• Durable medical equipment – must be accredited and possess a surety bond; if applicable
• Independent speech language pathologist
• Registered dietitian, diabetic educator and nutritionist
• Counselor therapists

**Provider/facilities eligible for affiliation in The Health Plan network are:**

• Ambulatory surgical centers – must be accredited
• End-stage renal disease facilities
• Federally qualified health centers
• Rural health clinics
• Home health care facilities
• Infusion therapy providers – must be accredited
• Hospitals – must be accredited
• Critical access hospitals
• Long-term acute care hospitals
• Outpatient physical therapy facilities
• Skilled nursing facilities
• Accredited behavioral health facilities

Providers and facilities must meet certain requirements to be a participating provider with The Health Plan. Please contact our contracting department or provider relations department for specific requirements by calling 1.800.624.6961.

The agreement will not be executed on behalf of The Health Plan until the credentialing process has been completed and the practitioner has been approved for participation. Practitioner cannot see members of The Health Plan until they are fully credentialed with the plan.

Notification of acceptance and/or rejection will be sent, in written form, within 60 days of the decision.

The Health Plan will complete the credentialing process within 90 days of receipt of the application or 180 days from the date of signature on the attestation statement of the application.

**In addition to the above credentials, The Health Plan quality improvement committee has identified the following behaviors and expectations for The Health Plan physicians, who should:**

• Have 24-hour availability, seven days a week, with backup coverage
• Accept members of any or all THP products, as required by The Health Plan
• Admit THP patients to participating hospitals
• Accept and support The Health Plan policies
• Allow medical records and office to be reviewed as part of a collaborative quality program
• Have records and office meet criteria established by The Health Plan and participating physician
• May not discriminate against The Health Plan patients or “de-market” The Health Plan
• Admit under own service to participating hospitals if patient’s condition is within physician’s range of expertise and scope of privileges
• Meet the CME requirement that is required for state licensure
The following guidelines are for PCPs only:

A PCP shall be required to provide a minimum of 20 hours per week of patient care availability in a county to be considered as a PCP in that county. The only exception shall be practitioners who provide services at multiple sites.

In the instance of multiple sites, these shall be acceptable providing the alternate location is within 30 miles or 60 minutes driving time of the primary location and the alternate location meets all the necessary requirements, as determined appropriate by the credentials committee and/or the executive management team. The PCP must also provide coverage 24 hours a day, seven days per week and have privileges at a provider facility or have arranged with a contracting provider/hospitalist group to handle all inpatient care for his/her patients.

The PCP maintains at least 50% primary care practice.

The following guidelines are for specialty providers (specialists and secondary care physicians):

Specialist practitioners who provide patient care access fewer than 20 hours per week in a THP county shall be considered as a practitioner in that region only if the specialty service of the physician is not otherwise available through sufficient plan practitioners residing in that region. Furthermore, the ability of the specialist to provide the necessary service locally including inpatient care, surgery and backup support shall be considered by the credentials committee and/or executive management team in making the determination of the acceptance of the practitioner as a plan provider.

The committee shall consider the specific needs of the specialty and how the physician will accommodate his/her patient needs. Practitioners who provide only limited services locally shall not be permitted to be accepted as a plan provider. In addition, if it is determined that the physician specialty requires the physician to be available locally, the practitioner shall not be accepted as a plan provider.

Practitioners Credentialing Rights

The practitioner has the right, upon request, to review information in support of his/her credentialing/recredentialing application by contacting The Health Plan credentialing department at 1.740.699.6279 or 1.800.624.6961, ext. 6279. The review will be at The Health Plan office and limited to the results of the primary verification of credentials. References, recommendations or other peer review protected information will not be shared with the practitioner.

The practitioner has the right to correct erroneous information. Any omissions, inconsistencies or erroneous information that is discovered during any of the listed verification processes will require further investigation by the director/manager of credentialing services. The director/manager of credentialing services will review the information to determine if it needs to go to the medical director for direction or select a course of action that may include:

- The manager of credentialing will send a written notice to the practitioner along with a copy of the application containing the discrepancy. The letter will state that the provider has 15 calendar days to respond in writing to the request for correction/update. If there is no written response received within the 15-calendar day timespan, a credentialing representative will contact the office via email or phone to ascertain why there has been no response. Once contacted, the practitioner is afforded an additional 15 calendar days to reply. The written explanation must be
returned by secure fax at 740.695.7883 or via postal mail to the manager of credentialing, or the credentialing representative listed on the letter, to 1110 Main Street, Wheeling WV, 26003.

If no response is received within 15 days of contact by the credentialing representative, the file will be placed in an inactive file and the practitioner will be notified of this status by letter.

- Once the information is received, the practitioner will be notified via email, fax, or telephone by the manager or a credentialing representative. The information will be taken to the medical director and/or blinded and taken to the credentials committee, along with the explanation from the practitioner, for the committee’s acceptance, acceptance with restrictions, or rejection.

The practitioner has the right, upon request, to be informed of the status of their credentialing or recredentialing application. The information that will be afforded to the practitioner includes if the application is still in process, it is pending to the credentials committee or in review by the medical director awaiting sign-off. The practitioner may request status by contacting The Health Plan credentialing department at 1.740.699.6279 or 1.800.624.6961, ext. 6279 or via e-mail at hpecs@healthplan.org. The practitioner will be contacted by telephone or mail with the response to his/her request for application status. This response will be within 5 business days of the request.
Initial Certification

During the credentialing procedure, information that the physician submits to The Health Plan as part of the application process is verified. This information includes, but is not limited to, medical licensure and board certification, plus the credentials listed in a previous section. In addition, each primary care physician, OB/GYN and designated high-volume specialist who provide medical service to Medicaid recipients must take part in an office site survey at the initial credentialing process, unless the practitioner has joined an existing group and that office has previously completed a site survey. Applicants and their practices are reviewed using certification standards developed by The Health Plan and approved by The Health Plan’s physician committee.
The Health Plan Standards for Patient Records

The medical record should be organized with the various types of information placed in a consistent location to enable easy access for reviewing the chart. Practitioners are responsible for medical records that were created in their office only.

1. **Patient Identification**
   Each page in the record or electronic file contains the patient's name and date of birth or chart ID.

2. **Advance Directives**
   There is evidence that advance directives have been executed or that information regarding advance directives was provided to The Health Plan members age 18 and over.

3. **Completed Problem List**
   A problem list noting significant and/or chronic medical/surgical conditions is in the medical record.

4. **Completed Medication List**
   Medication list includes name of medication, dosage, frequency, start date and stop date. The medication list should be reconciled at each visit. Any change to medications requires either dating and initialing the change or entering a stop date for the initial entry and re-entering the medication with the change. For patients that have had admissions to an acute or non-acute facility, the medication reconciliation should include documentation indicating current medications and discharge medications were reconciled.

5. **Allergies and Adverse Reactions**
   Medication/food allergies and adverse reactions are prominently noted in the record. Absence of allergies should be recorded as NKA. The documentation for allergies should be in a consistent location in all charts.

6. **Provider Identification**
   All entries in the medical record should contain the author's signature and credentials. (If EMR, electronic signatures and credentials are acceptable). Initials may be used only if there is a signature log identifying first initial, last name, and credentials. This standard excludes ancillary documents such as problem list, medication list, flow sheets e.g., The Health Plan Diabetic Flow Sheet.

7. **Dated Entries**
   All entries are dated.

8. **Legibility**
   The record is legible to someone other than the writer. Any record judged illegible by one physician reviewer should be evaluated by a second reviewer. A second reviewer can be office staff. Non-compliance occurs when a second reviewer cannot read the entry.
9. **Vital Signs: Blood Pressure**  
Blood pressure measurements should be checked using an optimal technique at every visit with a primary care physician and recorded in the medical record. If the blood pressure reading is abnormally high or abnormally low based on the patient's age, gender, medical/surgical conditions, etc., the blood pressure measurement should be repeated. Both blood pressure readings should be recorded.

10. **History and Physical (H&P)**  
The history and physical documents contain subjective and objective information. H&Ps performed by other medical professionals participating in a member’s care meets compliance. Patient-completed questionnaires count as evidence of compliance for the history component.

11. **Lab/Other Studies**  
All lab and other studies are ordered as appropriate for member age, gender and symptoms, as well as chronic conditions per The Health Plan guidelines.

12. **Plan of Action/Treatment**  
There must be evidence of a plan of action/treatment for presenting problem(s).

13. **Return Visit/Follow-Up**  
Encounter forms or notes have a notation, when indicated, regarding follow-up care, calls, or visits. The specific time of return is noted in weeks, months, or PRN.

14. **Problems from Previous Visits**  
Unresolved problems from previous office visits are addressed in subsequent visits. An unresolved problem is defined as an illness or symptoms that are not responding to treatment.

15. **Pain**  
Documentation in the medical record must include evidence of a pain assessment and the date it was performed. This may include a result of an assessment using a standardized pain assessment tool such as a numerical rating scale or pictorial pain scales for example or documentation including negative or positive findings for pain.

Screening for chest pain alone or documentation of chest pain alone does not meet overall pain assessment.

16. **Cognitive and Physical Development/Functional Assessment**  
Cognitive assessment is meant as an assessment of conscious intellectual activity (as thinking, reasoning, remembering, imagining, or learning words). Assessing and documenting cognitive status on an annual basis during the annual wellness visit, allows practitioners an opportunity to identify delays in mental developmental for children and monitor cognitive decline in patients over time.

Physical development and/or functional assessment is meant as an objective review to identify the milestones of normal growth and development and the signs of developmental delay for children as well as, prevent functional decline, and improve health-related quality of life. Optimizing functional status as an outcome of care is not limited to the elderly but is of major concern for individuals of all ages with chronic illness or disability. Functional status can include such things as ambulation/mobility, sensory ability (hearing/vision/speech), taking medications, ADLs and self-care to name a few.
17. Continuity and Coordination of Care
   If a consultation is requested, there should be a note from the consultant in the record. The record should indicate communication and feedback between the primary care physician and all specialists. Specialists that necessitate patients’ having frequent visits (ex: daily, biweekly, weekly) for care and treatment purposes such as chemotherapy, physical therapy, counselor/therapists, wound care etc. do not need to provide feedback with each visit. It is expected that any positive and/or negative outcomes be relayed to the primary care provider timely.

18. Emergency Room Visits
   There is evidence in the medical record of visits to emergency rooms, when applicable.

19. Hospital Admissions
   There is evidence in the medical record of admissions to hospitals, when applicable.

20. Tobacco Use
   For patients age 11 and over, assessment of the use of tobacco and smokeless tobacco must be documented. Counseling must occur with identification of tobacco use.

21. Alcohol Use
   For patients age 11 and over, assessment of the use of alcoholic beverages must be documented. Counseling must occur with identification of alcohol use.
   For patients age 21 and over, assessment of the use of alcoholic beverages must be documented. Moderate drinking is defined as no more than one drink a day for women and no more than two drinks a day for men. Twelve ounces of beer; 5 ounces of wine; or 1.5 ounces of distilled spirits (80 proof) counts as one drink. Counseling must occur if alcohol abuse is identified.

22. Substance Abuse
   For patients age 11 and over, assessment of substance abuse must be documented. Counseling must occur with identification of substance abuse.

23. Preventive Services
   There is evidence that preventive screening and services are offered in accordance with The Health Plan Preventive Health Guidelines.

24. Immunization Record
   An immunization record for children and adults is up-to-date according to The Health Plan Preventive Health Guidelines. Practitioners not providing immunizations in their offices are responsible for obtaining updated information from the source providing the immunizations.

25. Audit Trail
   The office maintains an audit log to track access to patient information including username, document(s), and description of use.
Electronic Health Record (EHR)

1. **Copy/Paste or Cut/Paste**
   The office has a policy/procedure to monitor and audit information "copied and pasted" or "cut and pasted" into the EHR to ensure copied information includes proper validation including name, credentials, date, time, and source of data.

2. **Defaults**
   Defaults are defined as data that is entered that does not require a positive action or selection, or data is entered by abbreviated words or keystrokes.
   The office has a policy/procedure to verify the validity of auto-populated information.

3. **Multiple individuals adding text/addendums to the same process note, entry, flowsheet**
   Documents with multiple authors or contributors retain signatures so that each individual’s contribution is clearly identified.

4. **E-prescribing**
   For offices currently utilizing E-prescribing, they have a policy/procedure for monitoring to prevent fraud, waste, and abuse.

5. **Technical Specifications**
   The office has a policy/procedure such as a backup system to prevent loss or destruction of EHR.

6. **EHR Health Information Exchange**
   The office has a policy/procedure to ensure secure, authorized electronic exchange of patient information.

Resources used in standard development:
- The Bureau for Medical Services (BMS)
- Centers for Disease Control
- The Centers for Medicare and Medicaid (CMS) Quality Improvement Standards
- Qlarant (formerly Delmarva) Quality Improvement Standards
- The Health Plan Guidelines
- The Health Plan Quality Improvement Committee
- US Department of Health and Human Services
Medical Records and Confidentiality Statement

The medical records and confidentiality statement ensure that a separate comprehensive medical record is created and maintained in a confidential manner for each member, as well as, provides easy access to all biographical and medical information and promotes quality care.

All participating physicians and providers shall maintain a separate onsite and up-to-date member medical record in accordance with The Health Plan standards for patient records. Providers shall comply with all federal and state laws and regulations which are consistent with good medical and professional practice.

All physicians shall preserve all records related to members for a period of not less than 10 years and retain records longer if the records are under review or audit.

The medical records shall be made available, as needed, to each physician treating the member. These records will be made available upon request of an authorized representative of The Health Plan for medical audit, utilization review, fiscal audit, and other periodic monitoring.

All medical records and discussion of details regarding patient information should only take place to complete normal job duties. Such discussion outside of regular working duties and home is strictly prohibited.

Members shall have the opportunity to approve or deny the release of identifiable personal health information by the physician or the provider except when the release is required by law. Member information shall not be released without signed authorization.

Copying member medical records and other data containing patient health information should be kept to the minimum that is needed to accomplish the required job. Member information, whether personal or medical, shall be released only when necessary.

All member’s medical record information should be kept confidential.

- All files should have limited access and not left open where they could be casually read.
- Computer system files require special password capability for access. All computer terminals accessing the mainframe should be logged off at the close of each day to prevent unauthorized access to system data.

All member medical records requiring disposal should be placed in appropriate receptacles for shredding. Burning may be used in lieu of shredding.

All physicians should require the review of this policy with any new employee, and with all employees on an annual basis.
Office Procedure Review

The Office Procedure Review form is available here.

Signature Log Form

Physician offices should sign all entries in patients’ charts either by a signature or initials (full name and title). When initials are used, a record of the initials, along with the person’s name, should be kept on file in each office.

For your convenience, we have devised a signature log for your use and is available here. The form contains the following sections:

- **Legible name** — print the employee’s name
- **Credentials** — MD, DO, DPM, DDS, CNP, NP, PA, etc.
- **Legal signature with credentials** — have the employee sign their name with credentials
- **Any signature variations** — employee signature if different from their legal signature

The signature log form may be reproduced.

Onsite visits of physician offices will be conducted spontaneously to review charts, office procedures, hazardous waste disposal and pharmaceutical and narcotic storage.

The network provider engagement department attempts to educate offices regarding these areas as we receive additional information. It is the office’s responsibility to implement these procedures.

The contact information for the provider engagement representative assigned to your county can be located on the website under “For Providers,” “Meet the Provider Engagement Team.”

Telephone Message Form

At the request of many offices, we have devised a telephone message form for your use. This form contains the necessary information needed to document phone calls received from patients. It provides space for recording times and intervention that may be important. By using this form, you may reduce the number of messages contained in your charts.

In today’s legal climate, it is increasingly important to document information accurately and in a comprehensive manner. One office had indicated that a form such as this afforded them the protection and documentation necessary to defend their office against a liability claim.

Use of this form is recommended but not mandatory. The form is available here.
## Phone Directory

The Health Plan General Telephone Number: 1.800.624.6961

<table>
<thead>
<tr>
<th><strong>ASO Benefits, Claim Status and Pre-Authorization Intake Reps (Providers Only)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self-Funded (ASO)</strong></td>
</tr>
<tr>
<td>Zappos.com</td>
</tr>
<tr>
<td>Murray Groups</td>
</tr>
<tr>
<td>All Other ASO Groups</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Benefits, Eligibility, Claim Status and Pre-Authorization (Provider or Members)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HMO, PPO &amp; POS</strong></td>
</tr>
<tr>
<td>Medicare</td>
</tr>
<tr>
<td>Medicaid</td>
</tr>
<tr>
<td><strong>Self-Funded (ASO)</strong></td>
</tr>
<tr>
<td><strong>Coordination of Benefits (COB) Issues and Questions (Providers or Members)</strong></td>
</tr>
<tr>
<td><strong>All Lines of Business</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Member Questions, Changes, Complaints and Concerns</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HMO, PPO &amp; POS</strong></td>
</tr>
<tr>
<td>Medicare</td>
</tr>
<tr>
<td>Medicaid</td>
</tr>
<tr>
<td><strong>Self-Funded (ASO)</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
Section 18

Compliance, Fraud, Waste and Abuse
Fraud, Waste and Abuse Regulations and Guidelines

Fraud, Waste and Abuse (FWA) Policies and Related Laws

The Health Plan’s fraud, waste and abuse policies were established to prevent, detect and correct fraudulent, wasteful or abusive practices perpetrated by employees, members, providers and facilities, including providers and facilities not contracted with The Health Plan. Compliance with these policies is the responsibility of each and every employee and anyone providing services to members of The Health Plan. Providers should ensure that ALL staff are thoroughly educated on state and federal requirements and that appropriate compliance programs are in place. The Health Plan expects its first tier, downstream, and related entities (FDRs) and its providers to operate in accordance with all applicable federal and state laws, regulations, and Medicare and Medicaid program requirements including, but not limited to the following:

1. **Health Care Fraud (18 U.S.C. §1347)**
   The Health Care Fraud statute makes it a crime for anyone to knowingly and willfully execute or attempt to execute a scheme to defraud any health care benefit program or to obtain by false or fraudulent pretenses, representations, or promises any of the money or property from a health care benefit program in connection with the delivery of or payment for health care benefits.

   The Federal False Claims Act (FCA) prohibits any person from engaging in any of the following activities:
   a. Knowingly submitting a false or fraudulent claim for payment to the United States government;
   b. Knowingly making a false record or statement in order to get a false or fraudulent claim paid or approved by the government;
   c. Conspiring to defraud the government in order to get a false or fraudulent claim paid or approved by the government; or
   d. Knowingly making a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the government.

   Federal law makes it a criminal offense for anyone to make a claim to the United States government knowing that it is false, fictitious, or fraudulent. This offense carries a criminal penalty of up to five years in prison and a monetary fine.

4. **Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b))**
   This statute prohibits anyone from knowingly and willfully receiving or paying anything of value to influence the referral of federal health care program business, including Medicare and Medicaid. Kickbacks can take many forms such as cash payments, entertainment, credits, gifts, free goods or services, the forgiveness of debt, or the sale or purchase of items at a price that is inconsistent with fair market value. Kickbacks may also include the routine waiver of copayments and/or co-insurance. Penalties for anti-kickback violations include fines of up to $25,000, imprisonment for up to five years, civil money penalties up to $50,000, and exclusion from participation in federal health care programs.
5. **The Beneficiary Inducement Statute (42 U.S.C. § 1320a-7a(a)(5))**
   This statute makes it illegal to offer remuneration that a person knows, or should know, is likely to influence a beneficiary to select a particular provider, practitioner, or supplier, including a retail, mail order or specialty pharmacy.

   The Stark Law prohibits a physician from referring Medicare patients for designated health services to an entity with which the physician (or an immediate family member) has a financial relationship, unless an exception applies. Stark Law also prohibits the designated health services entity from submitting claims to Medicare for services resulting from a prohibited referral. Penalties for Stark Law violations include overpayment/refund obligations, FCA liability, and civil monetary penalties. Stark Law is a “strict liability” statute and does not require proof of intent.

7. **Fraud Enforcement and Recovery Act (FERA) of 2009**
   FERA made significant changes to the False Claims Act (FCA). FERA makes it clear that the FCA imposes liability for the improper retention of a Medicare overpayment. Consequently, a health care provider may now violate the FCA if it conceals, improperly avoids or decreases an “obligation” to pay money to the government.

**FWA Training and Education**

All health care practitioners/providers or staff who render health care services to Medicare Advantage enrollees, provide Medicare Part C services, administer the Medicare Part D prescription drug benefit, or provide services to Medicaid recipients should complete FWA training. FWA training may be completed through the practitioners’/providers’ own internal compliance program or using The Health Plan Compliance and FWA training slides available on The Health Plan website. FWA training should be completed upon hire (within 90 days) and annually thereafter.

Practitioners/providers must maintain records of their completion of FWA training, as well as their employees’, for a period of at least ten years.

**Reporting**

The Health Plan Special Investigations Unit (SIU) and Compliance Department actively review all reports of suspected FWA and non-compliance. To report suspected fraud, waste or abuse and/or suspected issues of non-compliance, call the hotline at 1.877.296.7283. The Health Plan maintains a non-retaliation policy for anyone reporting issues in good faith; everyone should feel confident that NO adverse actions can or will be taken for reporting issues of concern. All issues may be reported anonymously.

A number of resources, including training slides are available on The Health Plan provider portal under “Resource Library,” “Compliance.”
Special Investigations Unit

Medicaid and Medicare guidelines require The Health Plan to have an effective program in place to prevent, detect, and correct fraud, waste and abuse. The Health Plan values its relationship with providers and recognizes the importance of providing valuable care to the community. The Health Plan is committed to ensuring quality care for its members and proper payment to providers for services rendered. Safeguarding payment integrity is an integral part of maintaining this mutually beneficial relationship, honoring the commitment to The Health Plan’s network and its members, and ensuring compliance with federal regulations.

The Special Investigations Unit (SIU) plays a vital role in detecting, preventing, and correcting fraud, waste and abuse, in ensuring payment integrity, and in recovering overpayments as required by state and federal regulations. SIU activities may include, but are not limited to, data mining, pre- and post-payment reviews, site visits, audits, and the facilitation of provider self-audits. In the event fraud or abuse is suspected, information is referred to the appropriate regulatory authorities and/or law enforcement.

The SIU utilizes a skilled team capable of analyzing, auditing, and investigating claims. Providers may be contacted by the SIU as a result of routine post-payment monitoring, or in response to a specific concern. Providers are expected to cooperate with the SIU and must comply promptly with requests for records or other information to ensure timely completion of audits and reviews.

Provider Self-Audits

All parties have an obligation to ensure that submitted claims are billed and paid properly. Federal and state regulations require managed care organizations that serve the Medicaid and Medicare populations to have procedures in place designed to detect and prevent fraud, waste, and abuse.

The Health Plan is committed to ensuring payment integrity across all lines of business. In furtherance of this objective, the Special Investigations Unit (SIU) may review paid claims either as part of a proactive payment integrity program, or in response to specific allegations. One tool the SIU incorporates into its payment integrity processes is the provider self-audit.

A provider self-audit is an audit, examination, or review performed by and within a provider’s business. A self-audit may be performed proactively by a provider as part of their own efforts to ensure payment integrity or at the direction of The Health Plan based on the discovery of questionable billing patterns. Self-audits are often preferred by providers because they are reviewing their own records, versus having SIU staff and/or government regulators on-site conducting an in-depth review. Additionally, a self-audit process is generally educational for the provider and their billing staff, resulting in a greater likelihood of future compliance.

Self-audits will be narrowly focused while still sufficient to address the relevant issues and will be limited in scope and duration. Self-audits may be utilized for cases meeting the following criteria:

1. Clear indications that an overpayment has occurred;
2. The overpayment is likely to be expansive;
3. No previous or immediate indicators of intent to defraud; and
4. High likelihood that the issue(s) can be resolved without significant SIU intervention.
Providers will be notified in writing when a self-audit is required. Self-audits will be designed on a case-by-case basis, depending on the specific circumstances giving rise to the audit. However, in all instances a self-audit notification will include the purpose of the review, the universe of claims and how that universe was determined, a deadline for completion, and instructions on how to remit any overpayments. Overpayments made under any federal health insurance program must be recovered. Refer to Section 15 “Payment Voucher and Claims, Overpayments and Offsetting” in this manual for timelines and processes related to overpayment recoveries.

The self-audit results will be reviewed by The Health Plan. The SIU may review documentation to validate the results and/or may meet with the provider or their staff to discuss any questionable items or further concerns. The provider should maintain copies of self-audit information and documentation for future reference. The provider will be notified in writing upon conclusion of the self-audit review.

Acceptance of a provider self-audit or subsequent repayment does not necessarily constitute agreement with the audit results or the overpayment amount, if it is later discovered that the self-audit results contained material misrepresentations or that supporting documentation or other relevant information was altered.
Compliance Through Training

The Health Plan uses education as a tool to ensure our members receive the highest quality of care by you, the provider. We achieve this through periodic reminders, updates and by communicating various compliance topics to facilitate our preventative approach.

- 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.
- Annual D-SNP training and attestation are required if you provide health care services to five or more of The Health Plan’s D-SNP members in the prior quarter. Your provider engagement representative will contact you to inform you of the requirement to complete training and provide you with the training materials and attestation form.
- You are required to maintain evidence of training for 10 years. This may be in the form of attestations, training logs or other means determined by you to document completion of these obligations.
- It is recommended that you verify with your outside billing and/or management companies that they are conducting compliance and FWA training as part of the seven core elements of an effective compliance program.

For additional information or assistance, please contact the Provider Relations Department at providersupport@healthplan.org.
The Health Plan Resources

The Health Plan provides training materials to assist providers with required and recommended training. Please visit The Health Plan’s provider portal under “Resource Library” to take advantage of the following training documents:

1. THP Medicare Advantage D-SNP Training
2. FDR-Subcontractor Standards of Conduct
3. THP 2020 Hotline Poster (for download in your office)
4. THP Code of Conduct
5. THP Fraud, Waste and Abuse Training
6. OIG Training Roadmap for New Physicians
7. 2020 Cultural Competency and SDoH Provider Training

Government Resources

   oig.hhs.gov/authorities/docs/physician.pdf
2. Compliance Guidance for Medicare Choice Organizations
   oig.hhs.gov/fraud/docs/complianceguidance/111599.pdf
3. Health Insurance Portability and Accountability Act (HIPAA)
   hhs.gov/hipaa/for-professionals/index.html
4. Stark Law (Physician Self-Referral)
   cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/index.html?redirect=/PhysicianSelfReferral/

Compliance Through Reporting

The Health Plan believes it is the duty of every person who has knowledge or a good faith belief of a potential compliance issue to promptly report the 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 problem. This obligation applies to all of The Health Plan’s first tier, downstream and related entities (FDRs) and its contracted providers.

The Health Plan also believes that an issue involving potential or actual non-compliance or FWA can be best investigated and remediated if an entity feels comfortable reporting such incidents through designated channels. There are various mechanisms available to confidentially report compliance concerns or suspected FWA.

- If your organization does not maintain a confidential FWA and compliance reporting mechanism, The Health Plan provides
various reporting resources: a confidential FWA and compliance hotline at 1.877.296.7283, email at compliance@healthplan.org, SIU@healthplan.org or on our website at healthplan.org. These reporting mechanisms are available and widely publicized to all employees, providers and contractors to report potential issues involving FWA and/or non-compliance.

• The Health Plan has adopted and requires all FDR and provider entities to adopt and enforce a zero-tolerance policy for intimidation or retaliation against anyone who reports, in good faith, suspected or actual misconduct.

Federal law prohibits 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 a Medicare Advantage organization, Part D plan sponsor and Medicaid contractor, The Health Plan, its FDRs and providers are 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 contracting, and monthly thereafter, each First Tier Entity and provider must perform a check to confirm its employees, governing body, volunteers and downstream entities that perform administrative or health care services for The Health Plan’s Medicare and Medicaid lines of business are not excluded from participation in federally-funded health care programs according to the OIG List of Excluded Individuals and Entities and the Systems for Award Management (SAM) exclusion databases.

• Office of Inspector General (OIG) list of excluded individuals and entities: exclusions.oig.hhs.gov

• General Services Administration (GSA) Systems for Award Management (SAM): sam.gov/SAM/pages/public/searchRecords/advancedPIRSearch.jsf

• In the event any of your employees or downstream entities are found on either of these exclusion lists, you must immediately remove the individual/entity from work related directly or indirectly to The Health Plan’s Medicare and Medicaid programs and notify The Health Plan of your findings.

• You must maintain a record of checking the exclusion lists (i.e., logs or other records) to document that each employee and downstream entity has been checked through the exclusion databases in accordance with current laws, regulations and CMS requirements.

• For further information on exclusion list requirements, refer to §1862(e)(1)(B) of the Social Security Act, 42 C.F.R. §422.752(a)(8), 42 C.F.R. §423.752(a)(6), 42 C.F.R. §1001.1901, the CMS Managed Care Manual, Chapter 21, Section 50.6.8 and the CMS Prescription Drug Benefit Manual, Chapter 9, Section 50.6.8.

The Health Plan will continue to educate our providers with reminders, bulletins and updates to promote compliance, and foster a continued and long-standing relationship with all of our valued providers. Thank you for your dedication and continued hard work toward satisfying the overall health care needs of our members.

Other Resources:

1. Health Care Administrators Association (HCAA): hcaa.org
2. Health Care Compliance Association (HCCA): hcca-info.org
3. Society of Corporate Compliance and Ethics (SCCE): corporatecompliance.org
5. National Health Care Anti-Fraud Association (NHCAA): nhcaa.org
6. Institute for Health Care Improvement (IHI): ihi.org
HIPAA Privacy and Security

The Health Plan is committed to ensuring the privacy and integrity of our members’ protected health information, or PHI. HIPAA privacy rules mandate that The Health Plan and our business associates learn and apply the privacy and security rules regarding PHI and abide by them. An individual’s PHI must be protected.

PHI includes individually identifiable information that relates to an individual’s past, present or future health condition whether in written, spoken or electronic form.

**HIPAA, The Health Insurance Portability and Accountability Act, is a federal law that requires The Health Plan, our contracted providers and our First Tier, Downstream and Related Entities (FDRs) to:**

- Properly secure protected health information (PHI) (physically and electronically)
- Protect the privacy of member/patient information
- Abide by the “minimum necessary” standard for the use and disclosure of member/patient information
- Address member/patient rights for the access, use and disclosure of his or her health information

**The Health Information Technology for Economic and Clinical Health (HITECH) Act and the HIPAA Final Omnibus Rule updated the original federal HIPAA privacy and security standards to include:**

- Requirements for breach notification
- Member/patient rights to obtain electronic copies of their electronic health record
- Makes business associates directly liable for compliance with HIPAA provisions
- Increased fines and penalties for violations
- Civil penalties range from $100 - $1,500,000 per year
- Criminal penalties range from $50,000 - $250,000 and imprisonment of up to 10 years

**Who Does HIPAA Apply To?**

HIPAA laws and regulations apply to health plans, health care providers and health care clearinghouses as well as business associates who perform services on their behalf.

**Safeguarding PHI**

Here are some ways to protect member/patient information:

- Use PHI only when necessary as part of job duties
- Use only the minimum necessary information to perform job duties
- Double check printers, faxes and copiers when finished using them
- Never leave PHI unattended in a bag, briefcase or vehicle
- When mailing documents, verify that each page belongs to the particular patient
- Ensure that computers are locked when unattended
- Create strong passwords, and never share usernames or passwords
• Do not install unknown or unsolicited programs onto work computers
• Ensure that information on monitors/screens is not visible to patients or visitors
• Never share patient information through social media, even if it is public knowledge
• When discussing patient care, take steps to reduce the likelihood others will overhear
• Keep paper documents that contain PHI out of view from others
• Dispose of PHI properly when no longer needed.

These are just a few ways to help ensure the confidentiality of patient PHI. Truly protecting the information that is entrusted to healthcare providers requires a commonsense approach that depends upon strict adherence to established policies and procedures.

The Health Plan has implemented HIPAA related training for all of its employees, which is distributed to staff upon hire and annually thereafter. It is recommended that all entities who work with PHI establish their own privacy and security program for their individual organization, and execute an inclusive, well-rounded training regimen to keep employees informed of their responsibilities surrounding patient/member rights and protections under the law.

HIPAA information and related forms can be found on our website. Resources:

• U.S. Department of Health and Human Services- Office for Civil Rights (OCR): hhs.gov/hipaa/for-professionals/index.html
• HIPAA Frequently Asked Questions for Professionals (FAQs): hhs.gov/hipaa/for-professionals/faq