ProviderFocus
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REMINDER: Signatures, Credentials and Dates Are Important

THP requires that each entry in the patient's medical record contain an acceptable signature, credentials, and the date on which the provider performed a service. Visit the Centers for Medicare and Medicaid Services (CMS) website at cms.gov for more information on signature requirements.

Inside this issue …

Pregnancy Testing

Office-Based Medication Assisted Treatments

All laboratory and clinical testing ordered by a provider for members of The Health Plan (THP) must meet the definition of medical necessity.

Participation in an office-based Medication Assisted Treatment (OBMAT) program is not in and of itself sufficient justification for frequent pregnancy screening. THP defines frequent pregnancy screening as more than once per month.

Medical necessity criteria for pregnancy testing in an OBMAT program for substance use disorder (SUD) includes:

1. The patient is female, not postmenopausal nor has a confirmed pregnancy
2. The visit is an initial screen for entry into the practice; and/or
3. The patient has a history of engaging in high-risk heterosexual behavior (claim billed with ICD-10 diagnosis code Z72.51 and the provider has documented high-risk behavior in the medical record); and/or
4. The patient is complaining of symptoms possibly suggestive of pregnancy; and/or
5. The patient has reason to express concerns that she may be pregnant; and/or
6. The patient requires medical clearance for some type of procedure or medication which may be potentially harmful to the fetus; and/or
7. The patient requests pregnancy testing

A provider should judge for themself their degree of comfort with treatment agents containing both Naloxone and Buprenorphine and test, accordingly, documenting the need for such testing as ordered by the provider.

Fraud, Waste, and Abuse

As a participant in federally funded healthcare programs, The Health Plan (THP) is obligated to have systems and procedures in place to guard against fraud, waste, and abuse (FWA). THP promotes provider practices that are compliant with all state and federal laws.

Fraud is defined by the federal government as intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state laws.

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to federal programs, or in reimbursement for medically unnecessary services or services that fail to meet professionally recognized standards.

Waste is defined by the Centers for Medicare and Medicaid Services (CMS) as practices that directly or indirectly result in unnecessary costs to the program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Examples of FWA may include:

- Billing for services not rendered
- Upcoding: billing for a higher service than what was provided
- Unbundling: billing component codes individually when services should be grouped under one code
- Falsifying records: misrepresenting information, such as diagnosis, rendering provider, or location of treatment, that impacts reimbursement
- Performing medically unnecessary services, including overutilization of testing that lacks medical justification clearly documented in the patient's record
- Duplicate billing
- Billing for services provided by unlicensed or otherwise unqualified personnel
- Kickbacks: providing something of value in an effort to induce or reward the referral of patients

Consequences for providers committing FWA can be severe, and may include civil penalties, criminal convictions and fines, loss of provider license, and exclusion from federal healthcare programs which often also results in exclusion from commercial programs.

Healthcare fraud can adversely impact patients as well. When victimized by unscrupulous providers, unsuspecting patients may be subjected to unnecessary medical procedures or may be denied coverage or reimbursement due to erroneous information included in their medical records. For example, patients may be denied coverage if the falsified information makes it appear as if they have reached coverage limits. Further, their health and safety may be jeopardized when medical decisions are made based on their medical history and that history contains information that was falsified in order to increase reimbursement.

If you suspect fraud, waste, or abuse has occurred and it involves THP members, you may contact THP's Special Investigations Unit at SIU@healthplan.org or call 1.877.296.7283. You may also report it online at healthplan.org/report-healthcare-fraud. Reports can be made anonymously.

Low Income

Medicare Beneficiaries

The QMB (Qualified Medicare Beneficiary) Program is a Medicaid benefit that pays Medicare premiums and cost sharing for certain low-income Medicare beneficiaries. Federal law prohibits Medicare providers from collecting Medicare Part A and Part B co-insurance, copayments, and deductibles from those enrolled in the QMB Program, including those enrolled in Medicare Advantage and other Part C plans. If you are a PCP, THP has coded your patient rosters with a symbol to help you identify which of your patients meet this income level. Patient rosters are available on our secure provider portal located at myplan.healthplan.org.

Refer to the following CMS MedLearn Matters article for further guidance: cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersARticles/downloads/SE1128.pdf

The patient should make the provider aware of their QMB status by showing both their Medicare and Medicaid or QMB card each time they receive care. Providers may contact Medicare at 1.800.MEDICARE (1.800.633.4227) for additional information.

Call Option

For Providers Without a Specific Member Issue

The Health Plan has added a new call tree option for providers without a specific member issue. Call 1.800.624.6961 and press 2 for "Provider Line". Then press 5 to choose a provider issue not related to a specific member. You may then press: (1) for provider portal issues, (2) for EDI, or (3) leave a voicemail message to have your Practice Management Consultant return your call.

Keep Up To Date

Provider Information

It is very important to remember to contact The Health Plan with any changes to your office location, telephone numbers, back-up physicians and hospital affiliations. This information is necessary to provide the most current information to our members in the form of directories, whether they are electronic or paper.

The Health Plan has instituted a feature on our website to assist providers in verifying and updating information. It is located on the "Find Providers" button found on our corporate website at healthplan.org. After searching your name, view the provider details on file. Click the Verify/Update Practice Info button to submit corrected information or verify that the listed information is current and correct.

The Health Plan's Affirmative Statement Regarding Incentives

The Health Plan bases its decision-making for coverage of healthcare services on medical appropriateness utilizing nationally recognized criteria. The Health Plan does not offer incentives to providers or employees involved in the review process for issuing non-authorization nor does The Health Plan specifically reward, hire, promote, or terminate practitioners or other individuals for issuing denials of coverage. Also, The Health Plan does not offer incentives that foster inappropriate under-utilization by the provider, nor do we condone under-utilization, nor inappropriate restrictions of healthcare services.

D-SNP Required Annual Training

The Centers for Medicare and Medicaid Services (CMS) require annual training of providers that provide services to members of THP's dual-eligible special needs population (D-SNP).

If your practice includes D-SNP members, please remember to complete the training. THP's Practice Management Consultants (PMC) will contact identified providers that care for five or more D-SNP members in a calendar year to complete training and attest to the training.

Training materials and the THP Provider Training Attestation Form are available on The Health Plan's secure provider website, myplan.healthplan.org in the Resource Library, under "Training and Education."

Contact your PMC if you have any questions. Contact information for your PMC is available online at: healthplan.org/application/files/1816/4009/5534/12.17.2021_PS_Provider_Servicing_Contacts_Map.pdf.

THP HEDIS® and Quality Measures 2022

The National Committee for Quality Assurance (NCQA) developed and maintains the Healthcare Effectiveness Data and Information Set (HEDIS®). These performance measures have become one of the most widely used set of performance measures in managed care. HEDIS® reporting is a requirement of health plans by NCQA and the Centers for Medicare and Medicaid Services (CMS) for use in health plan accreditation, Star Ratings, and regulatory compliance.

The Health Plan (THP) collects HEDIS® data through a combination of surveys, medical record audits, and claims data. The data collected provides information regarding customer satisfaction, specific health care measures, and structural components that ensure quality of care. An outlined set of performance measures across 6 domains of care is required for reporting: Effectiveness of Care, Access/Availability of Care, Experience of Care, Utilization and Risk-Adjusted Utilization, Health Plan Descriptive Information, and Measures Collected Using Electronic Data Systems.

THP has developed a collection of documents to assist you in understanding and documenting quality of care based on HEDIS® evidence-based measures. Each document includes coding guidelines and standards, as well as information to alleviate the burden of medical record review and tips to improve your patient health outcomes and close gaps in care.

The 2022 Quality and HEDIS® Measure Guideline (which includes a comprehensive coding guideline for all 22 HEDIS® measures) can be found on THP's corporate website healthplan.org "For Providers," "Patient Care Programs," "Quality Measures."

If you have any questions, please reach out to your Practice Management Consultant (PMC). Contact information for your PMC is on our corporate website: healthplan.org "For Providers," "Overview," "Meet the Provider Servicing Team."

Honoring Your Patients' End-of-Life Wishes

Advance Care Planning

The greatest gift you can give your patient with a serious illness, and their families, is to honor their end-of-life wishes with advance care planning (ACP). Physician Orders for Life-Sustaining Treatment (POLST) is a movement to allow Americans better tools in communicating their healthcare wishes. Nationally, POLST is no longer a recognized acronym and different states use different names. In WV it is called a Physician Order for Scope of Treatment (POST), and in Ohio, it is referred to as Medical Order for Life-Sustaining Treatment (MOLST).

Regardless of what it is called, these medical orders are to be completed after you have had the conversation with your patients regarding their end-of-life treatment preferences. Documentation must be maintained in a prominent part of the member's current medical record as to whether they have executed an advance directive (AD). You or your patients who reside in WV can submit the POST to the WV eDirective Registry. This site securely stores advance care planning forms and makes them available for treating health care providers. For more information go to wvendoflife.org/wv-e-directive-registry. Your patients may also submit their advance directive to The Health Plan (THP) to be added to their member record.

For providers in WV, the POST is a medical form available online from West Virginia Center for End- of-Life Care, wvu.qualtrics.com/jfe/form/SV_3IzAfkjK1JwedYq. In Ohio, providers should refer to the website leadingageohio.org/aws/LAO/pt/sp/advocacy_molst for information on completing a MOLST.

Did you know that the Centers for Medicare and Medicaid Services (CMS) requires health plans to track and trend the number of members who have discussed ACP with their providers and have an AD in place? Please help us comply with this regulation by documenting your encounter with the appropriate coding.

Statin Therapy

For Patients with Cardiovascular Disease (SPC) Program Announced

According to the American Heart Association (AHA), Cardiovascular Disease (CVD) is listed as the underlying cause for 874,613 deaths in the United States in 2019. One of the main preventative measures for Atherosclerotic Cardiovascular Disease-(ASCVD) related deaths is initiating a statin in patient medication regimens. Statins work to reduce the risk of strokes and heart attacks by lowering cholesterol levels, enhancing functionality in the lining of the blood vessels, supporting the stability of atherosclerotic plaques, reducing oxidative damage, and preventing platelets from clotting.

The Health Plan has partnered with MagellanRx to implement the Statin Therapy for Patients with Cardiovascular Disease (SPC) program. This will target males 21-75 years old and females 40-75 years old who have ASCVD. The primary goal of the program is to help these members receive at least one moderate- or high-intensity statin this year.

MagellanRx will contact prescribers, members, and/or pharmacies to ensure that the patient's healthcare team is involved in adding statin treatment if deemed appropriate. MagellanRx's vital role can promote communication, fill in any gaps in patient care, and provide patient education/medication counseling. With all parts of the healthcare team working together, we hope to reduce the number of patients experiencing sequelae and/or death from ASCVD.

You may receive a phone call from MagellanRx to discuss statin use in this patient population. We appreciate your collaboration in elevating the lives of our members. Please contact our Pharmacy Department at 1.800.624.6961, ext. 7914 should you have any questions.

DME PAC Program

New HCPCS Codes and Prior Auth Changes

Effective March 1, 2022, eviCore healthcare (eviCore) is including two new HCPCS codes and terming one code for use in the Durable Medical Equipment (DME) post-acute care (PAC) program. HCPCS codes A4436 and A4437 are replacing HCPCS code A4397.

Effective June 1, 2022, eviCore is changing the following twenty-one (21) DME HCPCS codes from no prior authorization required to prior authorization required.

These changes affect the following lines of business (LOB) with The Health Plan (THP):

- Commercial (including HMO, POS, PPO)
- Medicare Advantage (including SecureCare, SecureChoice and Dual Eligible Special Needs Plan [D-SNP])
- Mountain Health Trust (including WVCHIP and WV Medicaid).

Please direct any questions regarding members of THP's Commercial, Medicare Advantage and Mountain Health Trust LOB to eviCore at 1.877.791.4101or email: clientservices@evicore.com.

THP's Self-Funded LOB is not managed by eviCore. However, these code changes also apply to our Self-Funded members, including the need for prior authorization. Questions regarding members of THP's Self-Funded LOB should be directed to 1.888.816.3096.

A4230	A4232	A4238	A4351	A4352	A4353	A4409
A4520	A4554	A6197	A9274	A9275	E0570	E0607
E2102	K0553	K0554	K1030	K1031	K1032	K1033

Member Rights and Responsibilities

The Provider Practitioner Manual describes the member rights and responsibilities in Sections 3 and 5. This manual is available on THP's corporate website, healthplan.org. To obtain a copy please contact the Customer Service department at 1.800.624.6961.

Online Provider Referral Form

Clinical Education & Prevention Programs

The Health Plan (THP) has a variety of clinical programs conducted by professional staff to help you achieve your patient care goals. To refer a member for a clinical services program evaluation, please complete the form provided at healthplan.org/providers/resources/physician-case-management-referral.

There are health, wellness and prevention programs to provide education, support and resources to members who may require assistance with improving nutrition, achieving a healthy weight, increasing physical activity, managing stress, identifying, and addressing depressive symptoms, tobacco cessation or facilitating access to community-based organizations to address Social Determinants of Health (SDOH) such as homelessness, lack of food or transportation issues.

Pregnancy Care Programs are available to both high and low risk members, as well as to members who may want to discuss family planning or birth control options.

Chronic Disease Management Programs are available and aimed at helping to educate members and reinforce provider treatment plans for members learning to live with and manage diabetes, coronary artery disease, congestive heart failure, and chronic obstructive pulmonary disease with or without comorbid depression.

Medical/Behavioral Health Case Management Programs are here to bridge gaps between moderate to high-risk members and providers. Program goals include increasing member understanding of their disease or condition, managing/controlling symptoms, adherence to medication regimens, removing any barriers to care and helping members gain control of their health and achieve optimum function.

THP Continues to Reimburse

Tobacco Cessation Counseling

Effective April 1, 2022, WV Medicaid/WVCHIP will no longer reimburse for tobacco cessation counseling in dental practices (HCPCS Code D1320) for members aged 12 – 21.

THP, recognizing the importance of tobacco counseling by all providers, will continue to cover this service for dental providers. In addition, THP will expand this service to now be available to WV Medicaid/WVCHIP members aged 12 – 64.

Members will be eligible to receive one (1) unit of service per year. The counseling service will be covered outside of the $1,000 benefit limit for adults. Reimbursement will be based on the current 2021 Medicaid dental fee schedule. Contact Skygen at 1.888.983.4690 or email info@skygenusa.com with questions.

New Place of Service Billing Code

Established by CMS

Effective January 1, 2022, the Centers for Medicare and Medicaid Services (CMS) created Place of Service code 10, which is for telehealth provided in the member's home.

Providers may begin submitting claims with this place of service code immediately for Mountain Health Trust (WV Medicaid and WVCHIP) members.

This new place of service code is effective beginning with date of service April 1, 2022, for Commercial, Medicare and Self-Funded/ASO members.

Providers should continue to bill Place of Service 02 for members receiving telehealth services while in a hospital or other facility that is not a private residence.

WV Medicaid Population

Behavioral Health Fee Schedule Adjustment

On March 31, 2022, the 70% fee schedule increase for certain behavioral health CPT codes for the West Virginia Medicaid population ended.

Effective April 1, 2022, the following behavioral health services will be reimbursement at 105% of the WV Medicaid fee schedule.

H0004	H0004HO	H0004HOHQ	H0004HQ	H0031	H0032	H0032AH
H0036	H0038	H0040	H2010	H2011	H2014HNU1	H2014HNU4
H2014U1	H2014U4	H2015U1	H2015U2	H2019	H2019HO	T1017

The WV Medicaid fee schedule may be accessed at dhhr.wv.gov/bms/FEES/Pages/WV-Medicaid-Physician's-RBRVS-Fee-Schedules.aspx.

Contact a Medicaid customer service representative at 1.888.613.8385 should you have any questions.

Peer Recovery Support Services

PRSS Announcement

Beginning October 1, 2022, the Bureau for Medical Services (BMS) will require board certification for all new and existing Peer Recovery Support Services personnel (PRSS) through the West Virginia Certification Board for Addiction and Prevention Professionals (WVCBAPP).

WVCBAPP certification requirements, applications and manuals may be accessed online at: wvcbapp.org/applications.

THP will not reimburse services provided by a non-WVCBAPP certified PRSS after October 1, 2022.

New EPSDT Rate

Enhanced Rate for Certain EPSDT Health Screenings

Effective January 1, 2022, CPT codes 96110 (developmental and behavioral screening) and 96127 (brief emotional/behavioral assessment) will reimburse at an enhanced rate when billed for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. The enhanced rate applies to services provided to the West Virginia Medicaid population only. Providers must bill these CPT codes with an EP modifier to receive the enhanced rate.

Providers should use either the EPSDT forms available via the WV Bureau for Public Health HealthCheck Program's website for documenting screening results or an electronic health record inclusive of the same data points. Forms may be accessed at: dhhr.wv.gov/HealthCheck/providerinfo/Pages/default.aspx

Pharmacy Management Updates

We may add or remove drugs from our formularies during the year. To view a list of the drugs on the formulary and/or initiate the exception process, please visit The Health Plan's corporate website: healthplan.org. Search under "For You & Family" "Pharmacy" "Formularies."

We may update policies throughout the year. The most up-to-date policies are located on the secure provider portal located at myplan.healthplan.org. Search under "Policies."

Out-of-Network and Tertiary Facility Transfers Require Prior Authorization

The Health Plan (THP) requires authorization prior to transferring patients to an out-of-network or tertiary facility. If you are unsure of a facility's status with THP or to request prior authorization, call THP at 1.800.624.6961.

Hours of Operation Reminder to Providers

The Health Plan ensures that practitioners offer hours of operation that are no less (in number or scope) than the hours of operation offered to non-Medicaid or non-Medicare members.

We Want to Hear From You

Providers, The Health Plan (THP) would love to hear your suggestions for articles to include in upcoming newsletters. Feel free to e-mail providernotification@healthplan.org with your ideas as we tailor to your needs.

Medicare Advantage members

Change in COVID-19 Claims Submission

The Centers for Medicare and Medicaid Services' (CMS) have changed the responsibility of reimbursement for the administration of COVID-19 vaccines and monoclonal antibody treatment.

Beginning with dates of service January 1, 2022, providers are to submit claims for the administration of any COVID-19 vaccine or monoclonal antibody treatment to THP's Medicare Advantage members to THP.

THP Medicare Advantage plans include SecureCare, SecureChoice and Dual Eligible Special Needs Plan [D-SNP].

For dates of service up to and including December 31, 2021, submit COVID-19 vaccine and monoclonal antibody treatment claims to the appropriate Medicare Administrative Contractor (MAC). Contact THP at 1.877.847.7907 with any questions.

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