THP’s web portal now has the ability to display information and receive claims for termed THP members. The provider must put the DOS that they are inquiring about after inputting the member’s ID number and/or name to receive eligi

Please feel free to contact the Provider Relations Department at 740.695.7901 if you have any questions/problems with the web portal.

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In-Office Diagnostic Testing

In order to perform certain procedures in your office, The Health Plan must have a completed In-Office-Procedures Form on file. This form identifies the equipment, personnel, and any and all certifications and accreditations applicable for the services you are providing, i.e., laboratory procedures and X-rays, as well as procedures requiring special equipment.

If a participating provider adds or receives additional training to render additional services or has new equipment in their office, please contact The Health Plan Network/Provider Relations to discuss these services. If The Health Plan is unaware of any changes to billing for services, we will not have our system set up to reimburse these new services. Our system has built in the services each of our providers render based on the training, specialty, and certifications on file. It is necessary to identify the new services rendered to update your provider file.

When purchasing new equipment and the representative selling the equipment advises The Health Plan will cover the service, please do not assume this is a correct statement. Contact your Provider Relations/Network Management representative to verify the service will be covered.
Effective for hospital claims with dates of service on or after October 1, 2016, The Health Plan Medicaid members will have the benefit of immediate postpartum placement of long acting reversible contraception (intrauterine devices [IUDs] and etonogestrel implants) immediately after delivery and prior to hospital discharge. Facilities will be permitted to bill the costs associated with the implantable devices as indicated below, and providers will be permitted to bill separately for professional services associated with the insertion of such devices.

Facilities

To receive reimbursement for the LARC device itself, hospitals must include on each Uniform Billing (UB-04) claim for delivery services the Healthcare Common Procedure Coding System (HCPCS) code that represents the device, as well as the International Classification of Diseases (ICD-10) Surgical and Diagnosis Codes that best describe the service delivered.

Additional reimbursement for LARC services shall be triggered by the inclusion of the following codes

- Z30.430 – encounter for insertion of intrauterine contraceptive device; and/or
- Z30.433 – encounter for removal and reinsertion of intrauterine contraceptive device.

And the inclusion of the code below that corresponds to the implanted device

- J7297 Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 3-year duration
- J7300 Intrauterine copper contraceptive
- J7301 Levonorgestrel-releasing intrauterine contraceptive system, 13.5 mg
- J7307 Etonogestrel [contraceptive] implant system, including implant and supplies

Reimbursement levels shall be based on the lesser of billed charges or on the reimbursement terms currently identified within the applicable participation agreement with The Health Plan.

Professional Services

Physicians may also receive reimbursement for immediate post-delivery LARC insertion professional fees by including on their billing form (CMS 1500 or electronic equivalent) the appropriate LARC insertion code with the family planning modifier as currently billed in an outpatient setting.

- 11981 – Insertion, non-biodegradable drug delay implant
- 58300 – Insertion, IUD

Reimbursement for professional services shall be based on reimbursement terms currently identified within the applicable participation agreement with The Health Plan.
The Health Plan encourages and promotes integrity, and an ethical, efficient and compliant approach to health care delivery and to management services. We are committed to conducting its business interactions with the highest ethical standards, in compliance with all applicable federal and state laws and regulations.

To further this approach towards health care delivery, The Health Plan has implemented a Compliance Program to ensure that we are compliant with applicable laws, rules and regulations; as well as reinforcing our commitment to compliance. The Centers for Medicare and Medicaid Services (CMS) requires that The Health Plan’s First Tier, Downstream and Related Entities (FDR) fulfill specific Medicare program requirements. The Code of Federal Regulations (C.F.R.) explains in detail the Medicare Compliance Program requirements and further described in the Medicare Managed Care Manual, Chapter 21-Compliance Program Guidelines and Prescription Drug Benefit Manual, Chapter 9-Compliance Program Guidelines released by CMS.

Please take some time to review our Standards of Conduct, Corporate Compliance Plan and Code of Conduct located on our website: healthplan.org/providers/support-and-service/compliance-fraud-waste-and-abuse

REMINDER: CMS Annual Training Requirements

CMS requires documentation from our providers of the completion of the compliance training in FWA on an annual basis. This will assist in meeting the regulatory requirement for training and education. The FWA training is a requirement of the Social Security Act, CMS, Office of Inspector General (OIG), and HIPAA privacy regulations, as well as state Medicaid programs.

• The training must be completed within 90 days of the initial hire or the effective date of contracting and at least annually thereafter.

• You are required to maintain evidence of training; this may be in the form of attestations, training logs or other means determined by you to best represent completion of your obligations.


REMINDER: Signatures, Credentials and Dates Are Important

Each entry in the patient’s medical record requires the acceptable signature, including credentials and the date of the person writing the note.
Physician credentialing is necessary to receive in-network reimbursement from insurance plans. Procrastination and haphazard processing can spell cash-flow disasters for your new provider. Fortunately, there are ways to minimize issues with credentialing. Here are five simple yet proven techniques to improve your credentialing success.

1. **Start early.** Be aware that most commercial insurance credentialing and contracting can take 60–120 days on average. Many new practices or practices hiring a new provider make the mistake of beginning the process a month prior to a desired start date and then become frustrated when they cannot receive in-network reimbursement for another 2-4 months until the process is complete. The credentialing process verifies all of the provider education and training and then presents your file to the credentialing committee for approval. The approval/rejection is based on their internal credentialing policies.

2. **Pay attention to the details.** With such a lengthy process ahead of you, don’t delay your implementation by submitting credentialing applications with missing or incomplete information. Here are some of the most common errors found on payer enrollment applications:

   - **Incomplete work history** – You must include your current practice and all prior professional work history since graduating medical school and your history must include mm/yyyy format on all start/end dates;
   - **Malpractice insurance** – You must include your current policy and up to 10 years policy history;
   - **Hospital privileges** – You must have admitting privileges to an in-network hospital in order to participate with a health plan. If you do not, then you will need to have an admitting arrangement in writing with another in-network physician who will attest to an agreement to admit any of your patients that require in-patient services;
   - **Covering colleagues** – You are responsible for providing coverage for patients 24/7 and will need to disclose colleagues who cover for you when you are away. This is particularly important for solo practitioners;
   - **Attestations** – Fully answer all yes/no questions on each application and provide complete details for response when necessary.

Getting your applications correct the first time will minimize the time delays for your new provider.

3. **Stay current with CAQH.** A current CAQH profile is an important part of commercial insurance credentialing. Make certain that your CAQH profile is current with all personal details, attestations, signature pages, and required documents. A majority of commercial payers utilize CAQH to retrieve the bulk of credentialing information. An incomplete profile will cause a delay in the process.

4. **Require involvement from your new provider.** When you hire new providers, make sure they know they are responsible for completing the credentialing process for all the payers with which your organization participates. Don’t think it is an inconvenience or offensive to new providers to require them to complete necessary credentialing documents; it is their absolute responsibility. In order for the practice to be paid for their professional services, they must go through the credentialing and contracting process with each payer. Best practice would be to link a provider start date to completing primary payer credentialing.

5. **Know your key payers.** Know which payers represent 80 percent of your business so that you can prioritize credentialing to complete those payer processes first. You can selectively schedule patients for your new provider based on which plans have completed until the new provider is fully credentialed.
Ensure Timely Payment Through Proper Usage

Patient Suffixes

The Health Plan member identification cards have patient suffixes that should be included on the claim form to identify which family member is being treated. Single policies will not have suffixes other than 01 or 00 for the card holder. (Massillon area providers use 00.)

See the example to the right. Failure to include the patient suffix may result in a delay in claims processing.

Medicare Crossover

Effective 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 paid by Medicare. If Medicare denies the service, The Health Plan will also deny your claim.

If, in the future, The Health Plan decides to do Medicare crossover claims for other lines of business, we will notify you at that time.

Improving The Health Plan’s Rating

Rheumatoid Arthritis Stars Ratings

In an effort to improve The Health Plan’s Rheumatoid arthritis management star rating, The Health Plan will be requiring diagnosis validation for SecureCare Medicare populations. When a medical claim with a diagnosis of rheumatoid arthritis is submitted, the claim will now reject until the claim is validated. Validating should involve submission of diagnostic workup such as blood tests (ESR, CRP, rheumatoid factor, anti-CCP, etc.) and imaging tests (X-rays, MRI, ultrasound tests, etc.).

In most instances, validation of rheumatoid arthritis claims should be directed from the member’s rheumatologist. Claim validation has become necessary due to varying diagnoses from members’ treating physicians. We appreciate your attention to this matter and look forward to helping make this transition as smooth as possible. If you have any questions please call The Health Plan for further information.
Ensure patients come in to complete the required HEDIS services, receive vaccinations, and complete and record a BMI assessment.

Ask your patients and/or their caregivers to bring in their medications and conduct regular brown bag reviews to determine if the regimen is appropriate.

Help patients understand their medications and educate members on the importance of medication adherence.

Talk to patients about common problems and issues for Medicare members such as exercise, mental health, fall risk and bladder control.

Provide support to patients through referral and authorization processes.

Engage patients to understand their concerns, goals, medical history and disease states and to complete necessary procedures and schedule future visits.

Code what you discussed.

**Medicare**

**Prescriber Enrollment Info**

The Part D prescriber enrollment requirement means that beginning February 1, 2017, CMS will enforce a requirement that Medicare Part D prescription drug benefit plans may not cover drugs prescribed by providers who are not enrolled in (or validly opted out of) Medicare, except in very limited circumstances. Thus, for their prescriptions to be coverable under Part D, physicians, dentists, and eligible health professionals who write prescriptions for Part D drugs must:

- be enrolled in Medicare in an approved status, or
- have a valid opt-out affidavit on file.

Prescribers can refer to the following CMS website for more information: [go.cms.gov/PrescriberEnrollment](go.cms.gov/PrescriberEnrollment).

**Psychological Testing**

**Medicaid Coding and Pre-authorization**

CPT code 96119 - Neuropsychological Testing is not a covered benefit for Medicaid recipients and therefore will not be authorized or reimbursed by The Health Plan. CPT Code 96120 – Computer Based Testing is a covered benefit for Medicaid recipients. As a reminder, ALL psychological testing requires pre-authorization by The Health Plan’s Behavioral Health Services. Pre-authorization forms are available for download on The Health Plan’s website, [healthplan.org](http://healthplan.org), and completed forms may be submitted via the provider secure website, faxed to 1.866.616.6255 or emailed to BehavioralHealthDocuments@healthplan.org. Any documentation that contains member information must be sent securely.
The Health Plan Pharmacy Services, operating as THP Rx, has developed a new specialty pharmacy network! Beginning January 1, 2017, this new program allows The Health Plan to maximize patient safety and enhance patient management for obtaining best outcomes.

THP Rx partners only with URAC-accredited specialty pharmacies. These include Allied Health Solutions, Med Center Specialty Pharmacy, NuFactor for IVIG, Onco360 for oncology, and others. Upon the notification of approval, THP Rx will indicate the specialty pharmacy and their contact information to whom you can send the prescription.

Prior authorization forms for specialty medications can be found on The Health Plan’s website under the Provider section. You may fax prior authorization requests to 740.695.5297 or 1.888.329.8471 Attn: Pharmacy Department. If you have any questions or need to contact us regarding specialty medication requests, please call 740.695.7914, option 4.

Managing Your Employee’s Access

Provider Secure Web Portal

If you are the administrator for the secure website, it is your responsibility to maintain the users that have access to your group’s information. You can do this the next time you log in.

- Go to User Maintenance.
- Go to Manage Other User Rights. It will give a dropdown list of all users.
- Click on each user and check their ‘user rights.’ You can also update their email address or password.
- You can also de-activate the user. It is important to prohibit access of your information to former employees.

Below is a screenshot for your reference. For an active user, all fields would be complete and appropriate boxes would be checked.

2017 Guidelines for Prior Authorizations

Effective January 1, 2017, 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.

Non-participating providers rendering services to Medicaid members will be denied unless there is an approved authorization on file for the service.

New Medicaid Drug Screening Policy

Effective January 1, 2017, The Health Plan’s Medicaid line of business will be adopting BMS’ Drug Screening Policy. Providers can locate the most current policy, guidelines, and limits on the BMS website: dhhr.wv.gov/bms/Pages/Chapter-529-Laboratory-Services.aspx.

Member Rights and Responsibilities

We would like to remind all provider offices that the member rights and responsibilities can be found in the Provider Procedural Manual, Section 3. If you would like a copy please contact Provider Relations Customer Service at 740.695.7901 or 1.800.624.6961, ext. 7901.
The Health Plan has registered nurses who are certified case managers to coordinate health care services for members with catastrophic illnesses, injuries or behavioral health problems. If you have a patient you believe would benefit from the Case Management Program, you can contact the case managers by calling the Medical Department at 740.695.7644 or 740.695.7643 and toll-free at 1.800.624.6961, ext. 7644 or 7643. Contact Behavioral Health Services at 1.877.221.9295.

Also, The Health Plan website, healthplan.org, has detailed information regarding the Case Management Program, Behavioral Health Services and even an online Physician Case Management Referral Form to easily refer one of your patients.

Health Professional

Advice to THP Members

The Health Plan does not prohibit a health care professional from advising or advocating on behalf of their patients.

This includes:

• Providing a patient with information on health status, medical care or treatment, including alternative treatment that may be self-administered.

• Providing sufficient information to the patient to provide an opportunity to decide between all relevant treatment options.

• Discussing the risks, benefits and consequences of treatment vs. non-treatment.

• Providing the opportunity for the member to refuse treatment and to express preferences about future treatment decisions.