ProviderFocus
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Timely Claims Filing Change

Effective January 1, 2020, THP's timely claims filing deadline will change from 365 days from date of service (DOS) to 180 days from DOS for Commercial, Medicaid and Medicare lines of business.

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The HealthPlan

Retro Authorization Guidelines

Please be advised that all providers are required to request prior authorization for services identified on THP's preauthorization list before the service is rendered. Services requiring prior authorization are located on THP's provider secure website: myplan.healthplan.org.

THP will be strictly adhering to the prior authorization guidelines, effective September 16, 2019. This affects all THP contracted lines of business for medical and behavioral health services, making this requirement uniform for all THP contracted lines of business. This includes both outpatient and inpatient services on the preauthorization lists.

If a service that requires prior authorization is rendered after hours, over the weekend or on a holiday, providers are required to request authorization the next business day. Authorization requests received after the next business day will not be processed. Failure to follow prior authorization guidelines will result in denied claims.

If THP's clinical team determines that the service requested was not urgent/emergent, the request will not be eligible for further review due to failure to obtain prior authorization. All other retro authorization requests will not be considered as the provider failed to meet their obligation to have the service authorized in advance of services being rendered.

For all emergency issues, urgent/emergent transfers to tertiary facilities and for contacting the medical director after hours, please call THP's Physician Access Line at 1.866.687.7347 24 hours a day/7 days a week.

The SIU Department

Analyzes, Audits and Investigates Claims

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 and honoring the commitment to The Health Plan's network and its members, as well as complying 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 necessarily limited to, data mining, pre- and post-payment reviews, site visits, provider education, audits, and the facilitation of provider self-audits. In the event fraud 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 must comply promptly with requests for records or other information to ensure the timely completion of audits and reviews.

eviCore Partnership

THP announces its partnership with eviCore to manage medical necessity and prior authorization for the following services for all Medicaid, Medicare and fully insured lines of business.

Effective Date December 16, 2019:

- Sleep Studies
- Durable medical equipment (DME)
- Radiology
  - Advanced imaging (including cardiac advanced imaging: CT, MRI, PET)
  - Nuclear medicine (non-cardiac)
  - Ultrasound (including OB)

Effective Date January 1, 2020:

- Post-acute care (Medicare/DSNP only)
  - Skilled nursing
  - Home health
  - Long term acute care
  - Inpatient rehab

More information will be forthcoming as the implementation date draws nearer.

What Do You Know About

CAHPS & HOS Quality Measures?

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a survey administered by The Health Plan (THP) to random members to assess a patient's experiences with health care. This survey was developed by the Centers for Medicare and Medicaid Services (CMS).

The Health Outcomes Survey (HOS) assesses the ability of THP to maintain or improve the physical and mental health of its members over time.

CAHPS & HOS ratings account for more than a quarter of THP's overall CMS Star Ratings. These ratings also factor into the annual HEDIS® score. When ratings improve it is an indicator that the member is engaged in a healthier, happier and more productive life.

Physicians drive performance on the following CAHPS and HOS quality measures:

- Percent of patients who received the flu and pneumonia vaccine
- Patients rate how easy it was to get appointments with specialists to obtain needed care
- Patients rate how often they were able to get appointments and care quickly
- Patients rate on a scale of 0-10 their overall health care quality
- Patients rate on a scale of 0-10 The Health Plan overall
- The coordination of care composite measure rates the patients' experience with their physician's familiarity with their medical history and prescriptions, how well physicians are following up with patients after tests, and how well PCPs are communicating with specialists to coordinate care
- Patients rate how easy it was to use THP to obtain medications
- Patients report if their physical health is improving or maintaining
- Improving or maintaining mental health is reported as the same or better than the past two years
- Patients report whether they are monitoring physical activity
- Patients with urine leakage report whether they have improved bladder control
- Reducing the risk of falling is reported by patients who have had a fall or problems with balance

REMINDER: CMS Annual Training

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 which are available at myplan.healthplan.org. Training should be completed within 90 days of the initial hire date or the effective date of contracting and at least annually thereafter. You are required to maintain evidence of training for 10 years. This may be in the form of attestations, training logs or other means.

REMINDER: Signatures, Credentials and Dates Are Important

Each entry in the patient's medical record requires an acceptable signature and credentials, as defined by CMS, and the date on which the service was performed.

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.

Provider Training and Education Requirements for Medicaid Members

Substance Use Disorder (SUD)

Substance Use Disorder (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 for treatment of THP Medicaid members. During provider enrollment, the MCO 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 an appropriate application of, and fidelity to, the ASAM® Levels of Care and the Medicaid Provider Manual. THP 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.

Guiding Members Through Difficult Circumstances

Case Management Program

The Health Plan has a team of registered nurse case managers who coordinate health care services for members with catastrophic illnesses, injuries or behavioral health problems. If you have a patient you believe would benefit from the case management program, contact our Medical Department at 1.800.624.6961, ext. 7643 or 6100, or Behavioral Health Services Department at 1.877.221.9295.

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

Updated Formulary Exception Request Form

THP's Pharmacy Department permits physicians to request a coverage determination via phone at 740.695.7914 or through the website at healthplan.org. The Formulary Exception Request Form has been updated to include this information. This form may be accessed at: healthplan.org/formulary-exception-request-form

Non-Par Medicaid Provider Reimbursement

Effective August 1, 2019, unless prior authorized, all non-participating, non-patient facing providers providing services to West Virginia Medicaid members will be reimbursed at 80% of the current West Virginia Medicaid fee schedule.

Low Income Medicare Beneficiaries

Qualified 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. 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 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. Patients should not receive 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).

New Claim Edit Introduced

Over the past year, The Health Plan has successfully transitioned our electronic claims review process to incorporate Edifecs Transaction Manager. Currently, all default HIPAA EDI compliance checks (WEDI SNIP levels 1-6) are enabled, along with one payer defined edit (WEDI SNIP level 7), for a duplicate claim check.

THP is introducing an additional WEDI SNIP level 7 edit for eligibility. This edit checks the subscriber and patient demographic information in our system to determine if they are a THP member. The possible rejections you may see include:

- A3:158:QC: Subscriber/Patient DOB is incorrect. There could be a partial match of member ID and gender, but the submitted date of birth does not match the one in THP's system.
- A3:88:QC: Subscriber/Patient member ID is not in our system.

Help Us Keep Track of Changes

Keep Provider/Practice Info Up-To-Date

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. All of this information is gathered 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 a Doc tool found on our website at healthplan.org. After searching your name, view the provider details on file. Click the Verify/Update Practice Info button to submit the corrected information or verify that the listed information is current and correct.

Win a Catered Lunch

Complete DSNP Training to Be Entered

Congratulations to the office staff of Wood County Dialysis for completing their DSNP training and winning lunch delivered by The Health Plan. If you provide services to members of The Health Plan's dual-eligible special needs plan (D-SNP), you are required to complete annual training by the Centers for Medicare and Medicaid Services (CMS). Each quarter, The Health Plan will draw a winner from the providers that have completed and attested to their DSNP training to receive a catered lunch.

You may view the DSNP training slide deck and attest to the training by logging into The Health Plan's secure provider website, myplan.healthplan.org, or by contacting your provider engagement representative.

Prevention is the Name of the Game

Dental Visits for 2 to 3-Year-Olds

Oral health is an integral part of the overall health of children. Cavities and gum disease are one of the most common chronic diseases of childhood. Healthcare professionals play a key role in improving health outcomes for their patients. The goal of early risk assessments is to target infants and young children who traditionally have yet to establish with a dentist.

A dentist will develop an ongoing relationship with the patient for a continuation of care for the rest of their lives. A dentist will be able to provide accurate risk assessments, individual preventive health programs based on risk, anticipatory guidance regarding growth and development, and a plan for emergency dental trauma. Often the first step of timely establishment with a dentist is a referral from the primary care practitioner. Dentists allow primary care practitioners to focus on preventive oral care instead of focusing on disease states and treatment. The importance of the primary care practitioner is instrumental in providing risk-based preventive oral health care, anticipatory guidance and education.

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 and Section 5_21. This manual is available on our website, healthplan.org. If you would like a copy please contact Provider Relations Customer Service at 1.800.624.6961, ext. 7901.

Available Online

Clinical Practice Guidelines

The Health Plan and participating practitioners review and update the preventive health guidelines and clinical practice guidelines, which are available to you as a reference tool to encourage and assist in planning your patients' care. To help make the information more accessible and convenient for you, we post the complete set of guidelines online. Just visit healthplan.org/providers/patient-care-programs/quality-measures to view standards, guidelines and program descriptions for Quality Improvement, Disease Management and Behavioral Health practice guidelines.

Transportation Services

Medicaid Members

Non-emergency transportation services are available to Medicaid members to assist with keeping provider appointments to maintain good health. This is a benefit provided by Medicaid fee-for-service and 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. Medicaid members may call 1.844.549.8353 to arrange for transportation services.

Provider Notifications

THP Communications

THP's primary source of provider notification is via email. THP can store up to 10 emails per provider in the system. Unsubscribing from an email blast will unsubscribe a provider from all electronic communication, including the Provider Focus quarterly newsletter. Contact your provider engagement rep to add your email address under your provider/group tax identification number. Access the provider engagement territory map here: healthplan.org/providers/overview/meet-provider-engagement-team

Provider Practitioner Manual

The Provider Practitioner Manual is updated bi-annually in July and December and may be accessed on The Health Plan's website at healthplan.org/providers.

Facility to Facility Transfers

Prior authorization is required before transferring patients from one facility to another facility.

- **Contact THP's Admissions Line at 1.800.304.9101 24 hours a day, 7 days a week to notify THP of urgent/emergent admissions and transfers**
- **This number reverts to a voicemail notification after regular business hours.**

Referring Patients to Behavioral Health Providers

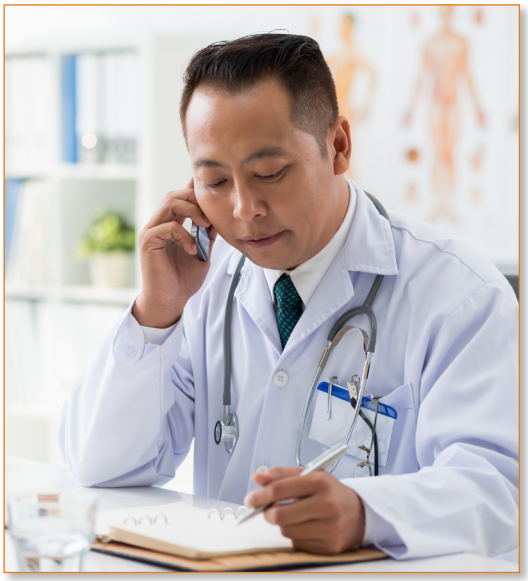
THP encourages PCPs to screen members for behavioral health needs and the PCP may assist in coordinating with THP to ensure the member receives the appropriate behavioral health services. THP offers access to the most current ADHD, depression and substance abuse guidelines on our website located at: healthplan.org/providers/patient-care-programs/quality-measures.

Substance Use Disorder (SUD) Form

Clinical Review Information Form

The Substance Use Disorder Clinical Review Information Form was implemented to collect demographic and clinical information on THP members for all lines of business and all services related to substance abuse treatment.

- This form replaces the following forms:
- Substance Use Disorder Admission Review Information Form
- Substance Abuse Concurrent or Discharge Review Information Form
- This form is located at myplan.healthplan.org/Home/ResourceLibrary



The HealthPlan

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