



Provider Manual

Corporate Office

1110 Main Street
Wheeling, WV 26003

P: 1.800.624.6961

F: 1.740.699.6169

TTY: 711

healthplan.org

Effective 07/01/2026

Revised 7/23/2026

This manual is intended for the sole use of the physicians of The Health Plan. Any reproduction or distribution of any part of this manual without written consent from The Health Plan is prohibited.





Table of Contents

Chapter 1 – About Us & Communicating With Us

Welcome.....	2
About Us.....	2
Communicating With Us	2
Provider Portal.....	3

Chapter 2 – Product Information

Product Information.....	6
West Virginia Medicaid.....	7
Commercial Fully Insured	7
Medicare Advantage.....	8
Self-Funded/Administrative Services Only	8

Chapter 3 – Claims

Claims Submission	10
Timely Filing and Timely Adjudication.....	11
Practitioner Overpayments.....	12
Practitioner Reconsideration (Appeal)	12
Coordination of Benefits (COB)	12
Documentation Submission	17
Never Events and Avoidable Hospital Conditions	17
Notice of Readmissions Review Occurring Within 30 Days	21
Remittance	21

Chapter 4 – Medical Records

Medical Records and Confidentiality Statement	23
Medical Records Request and Review	23
Standards for Medical Records.....	24
Evaluation and Management Services.....	26
Use of Imagery.....	27
Telehealth Services.....	27
Drug Screenings	27
Altered, Amended, or Addended Records.....	28
Templated, Copy-and-Paste, or Replicated Records.....	28
Electronic Health Resources (EHR).....	28
Common Coding Scenarios	30



Chapter 5 – Commercial Fully Insured and Self-Insured/Administrative Services Only

Commercial Health Maintenance Organization (HMO) Plans	32
Commercial Point-of-Service (POS) Plans	33
Commercial Preferred Practitioner Organization (PPO) Plans	34
Sample Commercial Member ID Cards	35
Self-Funded / Administrative Services Only (ASO) Employer Groups	36
Sample Self-Funded/ASO ID Cards	36
Vision Service Benefits	37
THP's Members' Rights and Responsibilities Statement	38
Member Copayments, Co-insurance & Deductibles	40
Affordable Care Act and Member Responsibility	41

Chapter 6 – Mountain Health Trust (MHT)

Mountain Health Trust (MHT) Program	43
Sample Mountain Health Trust Member ID Cards	44
Medicaid Benefits and Exclusions at a Glance	46
MHT Benefit Exclusions	57
Additional Resources for Mountain Health Trust Members	58
Practitioner Hours of Operation	59
Cultural Competency and Social Determinants of Health (SDoH)	59
Practice Training Guidelines	59
HealthCheck (EPSDT)	60
Medicaid Copays	61
Medicaid Prescription Benefit	62
WVCHIP Copays	63
Mountain Health Trust Out-of-Network Non-Patient Facing Practitioner Reimbursement and Emergency Reimbursement	65
Family Planning	66
Local Health Departments	66
Vaccines For Children (VFC) Program	67
Surgical Sterilization Consent Forms	67
Pregnancy Billing and Newborn Enrollment and Billing	68
Women's Access to Health Care	69
Tobacco Cessation	69
Diabetes	69
Medicaid Behavioral Health Services	70
WVCHIP Behavioral Health Services	70
Mountain Health Trust Behavioral Health Billing Guidelines	71
Medicaid Adult Dental	72
Medicaid Children's Dental	72



Chapter 6 – Mountain Health Trust (MHT)

Immunization Registry	73
Appeals and Grievances	73
Mountain Health Trust Members' Rights	77
Practitioner Reporting Requirements	80
Practitioner Fee Schedule Changes	81
Practitioner Overpayments	82
Alternative Payment Models (APMs)	82
Marketing Guidelines	83
West Virginia MHT Practitioner Required Provisions	86
MHT Drug Testing Policies	92
Transplant Services	92
Inpatient Claims	92
Medicaid NDC Rebate Eligible Drugs	93
Medicaid Emergency Room (ER) All-Inclusive Reimbursement Rate	94
Outpatient Services for Acute and Critical Access Hospitals	94
Indian Health Care Practitioners Disclosure	94
Member Incentives (Value Added Services)	95

Chapter 7 – Behavioral Health

SecureCare HMO Medicare Advantage Plan	97
Sample SecureCare HMO Medicare Advantage Member ID Card	97
SecureChoice PPO Medicare Advantage Plan	98
Sample SecureChoice PPO Medicare Advantage Member ID Card	98
Medicare Advantage Dual Eligible Special Needs Plan (D-SNP)	99
Sample Medicare Advantage Dual Eligible Special Needs (D-SNP) Member ID Card	101
Vision Service Benefit	102
Medicare Advantage Coordination of Benefits (COB)	102
THP Insurance Company Medicare Supplemental Plans	102
Medicare Non-Covered Service Guidelines	103
Quality Measures and Standards	105
Member Incentives	106
Appointment of Representative Statement for a Medicare Member	107
Notice of Medicare Non-Coverage (NOMNC)	108
Medicare Outpatient Observation Notice (MOON)	109
Medicare Appeals Overview	110
Low Income Medicare Beneficiaries	111
Medicare Practitioner Rights and Responsibilities	112
SecureCare/SecureChoice Member Rights and Responsibilities	113



Chapter 8 – Behavioral Health

Introduction	115
Review Criteria.....	115
Behavioral Health Prior Authorization	116
Inpatient Treatment, Detoxification, Rehabilitation of Substance Use Disorders and Observation Review	116
Outpatients Prior Authorization and Referral Management.....	118
Drug Screening and Testing.....	119
Behavioral Health Billing.....	119
Continuity and Coordination of Care.....	120
Behavioral Health Services Forms.....	120
Telehealth Services	121
Follow-Up Care after Behavioral Health Admissions	121

Chapter 9 – Clinical

Introduction	123
Prior Authorization Criteria	124
Medical Prior Authorization & Notification Requirements.....	124
eviCore healthcare.....	125
Nurse Information Line	126
Admissions/Concurrent Review Process.....	126
Medical Transition of Care Team.....	127
InterQual® Review.....	127
Requests for Second Opinion.....	127
Specialist Coordination of Health Care Services	128
Member Wellness, Prevention & Health Promotion.....	129
Care Coordination	130
Care Navigation	131
Complex Case Management.....	131
Chronic Disease Management Program	133
Family Planning, Well Pregnancy, and High-Risk Pregnancy Programs.....	134
What the Member and Practitioner May Expect with Care Coordination Program Enrollment.....	135
Advance Care Planning.....	136
Clinical Leadership and Committees.....	136
Quality Improvement Committee	138
Annual Utilization Management Program Description and Evaluation.....	139
Medical Economics.....	139
Quality Measures and HEDIS®.....	140



Chapter 10 – Pharmacy

Introduction 142

Clinical Criteria for Pharmaceutical Management Program..... 143

Pharmacy and Therapeutics Committee 143

Specialty Pharmacy Program 143

Pain Management Program and Opiate/Opioid Management..... 144

THP's Pharmacy Network..... 144

Formulary..... 145

Choosing a Preferred Drug Formulary..... 145

Pharmacy Prior Authorizations..... 147

Chapter 11 – Quality

Introduction 150

Clinical Care Quality Indicators..... 152

Practitioner Expectations..... 153

Chapter 12 – Credentialing and Data Management

Credentialing 158

Initial Credentialing 158

Recredentialing..... 159

Practitioner's Credentialing and Recredentialing Rights..... 159

Standards for Participation..... 160

Chapter 13 – Compliance

Provider Reimbursement Compliance..... 164

Fraud, Waste and Abuse Regulations and Guidelines..... 165

Special Investigations Unit (SIU)..... 167

Practitioner Compliance Training..... 170

Compliance Through Reporting..... 171

HIPAA Privacy and Security..... 172

Resources 173

Chapter 1

About Us & Communicating With Us





Welcome

The Health Plan of West Virginia Inc. dba The Health Plan (THP) appreciates its practitioners, hospitals, and ancillary providers and value your dedication and commitment to serve our community.

About Us

THP is a not-for-profit, 501(c)(4) corporation, chartered in West Virginia and headquartered in Wheeling. A Board of Directors represented by citizens of the communities in which we serve governs THP. The plan holds HMO Certificates of Authority in both Ohio and West Virginia. THP currently employs over 500 people throughout three office locations: Wheeling, Charleston, West Virginia, and Massillon, Ohio.

THP has been developing and implementing products and services that manage and improve the health and well-being of its members through a team of health care professionals and partners from across communities since 1979.

Communicating with Us

Our dedicated staff at THP will assist practitioners and members when issues, questions, or concerns arise. THP's hours of operation are 8 a.m. to 5 p.m. EST Monday through Friday.

We've compiled a quick reference guide that lists important contacts.

Customer Service – Assistance with Benefits, Eligibility, and Claims	
Commercial	1.888.847.7902
Self-Funded	1.888.816.3096
Medicare Advantage	1.877.847.7907
Mountain Health Trust (MHT) including WV Medicaid and WV Children's Health Insurance Program (WVCHIP)	1.888.613.8385
Behavioral Health	1.877.221.9295
Coordination of Benefits (COB)	1.800.624.6961, ext. 7903
eviCore Healthcare	1.800.918.8924
Emergency Nurse Line (24/7)	1.866.687.7347



Email Contacts	
Electronic Data Interchange (EDI)	edi@healthplan.org
Provider Data Quality (PDQ)	pdq@healthplan.org
Helpful Web Links	
Provider Manual	healthplan.org/providers/resources/provider-manual
THP Corporate Website	healthplan.org
THP Secure Provider Portal	myplan.healthplan.org
Provider Directory	findadoc.healthplan.org/
Practice Management Consultant	https://www.healthplan.org/providers/overview/meet-practice-management-consultant

Provider Portal

THP's MyPlan Provider Portal offers self-service options and resources. Access the secure provider portal at myplan.healthplan.org to log in or register.

1. View and Submit Claim Status

- Check claim status on all professional, institutional, and dental claims submitted to THP regardless of submission method i.e., clearinghouse, portal.
- Submit professional, institutional, and dental claims through the Axiom TransShuttle link on MyPlan.
 - Practitioners will need to register with this tool to data enter original, void, or corrected professional, institutional, or dental claims for THP members. Secondary claims are also supported.

2. View and Submit Prior Authorizations

Effective July 1, 2024: To comply with West Virginia prior authorization requirements, practitioners submitting prior authorization for MHT, Commercial, and PEIA plan members are required to submit prior authorizations through a health insurer's secure provider portal. Fax and phone prior authorization requests are not accepted.

- Medical and Behavioral Health, Durable Medical Equipment (DME), and Medical Pharmacy prior authorization requirement lists available
- Submit inpatient and outpatient prior authorizations through THP portal and depending on the patient's plan and procedure code, practitioners will be redirected through a single sign on to Helios or informed via a display message to visit EviCore to complete the authorization request and upload supporting documentation and notes.
- Status of authorizations submitted via THP portal can be obtained by accessing MyPlan and clicking Manage my Authorizations under Authorizations.
 - Status of eviCore authorizations can also be obtained by accessing eviCore.com/provider



3. Search Patients

- Access member demographic information and ID card and verify coverage, network, copays, and deductibles.

4. Member Roster

- PCPs: View and download all current or previous attributed members

5. Remittance

- View and download paper remittance copies

6. Resource Library

- Training and Education
 - General provider portal guide
 - General and Behavioral Health Toolkits
 - Prior authorization submission via provider portal user guide
 - Claims submission via provider portal user guides
 - Cultural Competency and Social Determinants of Health (SDoH)
 - Dual Eligible Special Needs Plan (D-SNP)
 - SDoH Provider Incentive Program
- Onboarding and Data Quality Forms
 - Credentialing
 - Practice Update
 - Practitioner Term
 - Remittance/Pay-To Update
- Additional Forms
 - Specialist as PCP
 - Documentation cover sheet

7. Dual Eligible Special Needs Plan (D-SNP) Model of Care (MOC) Training

- Medicare Advantage participating practitioners: View and attest to required training each calendar year

8. Manage my Members

- Prior Authorizations
- Member Rosters
- Quality measures tracker
- Hospital admission, discharge, and transfer information

Chapter 2

Product Information





Product Information

	Member selects Primary Care Physician (PCP)	Referrals required for Specialty Care	Member has open access to Specialty Care providers. <i>*Specialists may serve as a PCP if the specialist and member eligibility is met.</i>	Member has open access to Behavioral/Mental Health	Member has Out-of-Network Benefits
COMMERCIAL					
Fully Funded HMO	YES	YES. PCP must coordinate all specialty care and document all referrals in the patient's chart. Prior authorization must be submitted to The Health Plan for any out-of-network care.	Yes, for in-network specialist physician.	YES. Refer to Directory for participating providers.	NO
Fully Insured POS	YES	YES. PCP must coordinate all specialty care and document all referrals in the patient's chart. Prior authorization must be submitted to The Health Plan for any out-of-network care.	Yes, for in-network specialist physician.	YES. Refer to Directory for participating providers.	YES
Fully Insured PPO	NO	NO. Member may self-refer to any network specialist to receive in-network benefits.	Yes, for in-network specialist physician.	YES. Refer to Directory for participating providers.	YES
MEDICARE ADVANTAGE					
SecureCare HMO	YES	YES. PCP must coordinate all specialty care and document all referrals in the patient's chart. Prior authorization must be submitted to The Health Plan for any out-of-network care.	Yes, for in-network specialist physician.	YES. Refer to Directory for participating providers.	NO
SecureChoice PPO	NO	NO	Yes, for in-network specialist physician.	YES. Refer to Directory for participating providers.	YES
SecureCare D-SNP	YES	YES. PCP must coordinate all specialty care and document all referrals in the patient's chart. Prior authorization must be submitted to The Health Plan for any out-of-network care.	Yes, for in-network specialist physician.	YES. Refer to Directory for participating providers.	NO
MOUNTAIN HEALTH TRUST					
WV Medicaid Expansion/SSI/WVCHIP	YES	YES	Yes, for in-network specialist physician.	YES. Refer to Directory for participating providers.	NO
SELF-FUNDED/ASO *CONTACT THE HEALTH PLAN TO CONFIRM BENEFITS					
Self-Funded/ASO HMO, PPO, POS	PPO: NO HMO, POS: YES	PPO: NO. HMO, POS: YES. Services requiring referral/prior authorization may differ by plan sponsor.	Determined by specific employer benefits.	Determined by specific employer benefits.	Determined by specific employer benefits.
To verify eligibility or benefit information, visit the provider portal at myplan.healthplan.org .					



West Virginia Medicaid Mountain Health Trust

Medicaid is a federal and state government program that helps with medical costs for individuals with limited incomes and resources. Mountain Health Trust (MHT) is a West Virginia managed care program established by the Bureau for Medical Services (BMS). BMS is contracted with THP for the provision of Medicaid medically necessary services for eligible West Virginia residents.

Within the MHT product are four (4) plans:

1. **Temporary Assistance for Needy Families (TANF)** covers eligible individuals under age 19, adults that are a parent/caretaker with low or no income, and most pregnant women.
2. Under the Affordable Care Act, **Expansion** covers eligible individuals aged 19-64 with incomes up to 138% of the federal poverty level.
3. **Supplemental Security Income (SSI)** covers eligible individuals that are recipients of SSI payments and those that are aged, blind, or disabled.
4. **Children's Health Insurance Program (CHIP)** covers eligible individuals under age 19 that have incomes greater than 138% of the federal poverty level but less than 300% and pregnant women aged 19 and up that are between 185% and 300% of the federal poverty level

Commercial Fully Insured

Commercial plans are fully insured by a Health Insuring Corporation (HIC). Employers contract with THP to provide a health insurance benefit plan and pre-pay a monthly premium to cover eligible employees.

Individuals employed through the state of West Virginia covered by the Public Employees Insurance Agency (PEIA) plan are included in the Commercial product.

Within the Commercial product are three (3) plan types:

1. **Health Maintenance Organization (HMO)**
 - **West Virginia Public Employees Insurance Agency (PEIA)**
2. **Point of Service (POS)**
3. **Preferred Provider Organization (PPO)**



Medicare Advantage

Medicare is the federal health insurance program for individuals 65 years of age or older and under age 65 with certain disabilities. Medicare Advantage is a Centers for Medicare and Medicaid Services (CMS) approved product that provides eligible individuals additional benefits to original Medicare. THP is contracted with CMS to provide healthcare services to individuals eligible for Medicare and that choose THP as their Medicare Advantage Managed Care Organization (MCO).

Within the Medicare Advantage product are three plans:

1. **SecureCare Health Maintenance Organization (HMO)** covers eligible individuals for all Part A and B services. Cost sharing and provider access differ from original Medicare.
2. **SecureCare Health Maintenance Organization (HMO) Special Needs Plan (SNP)** covers Medicare beneficiaries who are also eligible for Medicaid.
3. **SecureChoice Preferred Provider Organization (PPO)** covers eligible individuals for all Part A and B services. Cost sharing and provider access differ from original Medicare.

Self-Funded/Administrative Services Only

THP contracts with employer groups to offer Administrative Services Only (ASO) that include administering the employers benefit plan, processing of claims, clinical management, etc. Employer group participation includes predictable, fixed monthly payments with composite rating.

The employer groups cover the employees' medical costs that are enrolled in the Self-Funded plan and THP operates as the Third-Party Administrator (TPA) to manage the plan.

For small employers, the Multiple Employer Welfare Agreement (MEWA) includes the Chamber Benefits Plan for eligible employers domiciled in West Virginia. For eligible employers domiciled in Missouri, MEWA includes the Missouri Chamber Federation Benefit Plan.

*To learn about benefits and more information for each plan above, visit the applicable chapter:

Chapter 5 – Commercial Fully Funded and Self-Funded/Administrative Services Only

Chapter 6 – Mountain Health Trust

Chapter 7 – Medicare Advantage

Chapter 3

Claims





Claims Submission

Practitioners, hospitals, facilities, and ancillary providers should submit THP network claims via their clearinghouse using payer ID 95677 (837 Institutional and Professional), payer ID 34150 (837 Dental), or through the THP MyPlan Provider Portal.

Paper claims must be submitted on red Optical Character Recognition (OCR) forms to:

The Health Plan
1110 Main Street
Wheeling, WV 26003

THP will not accept handwritten paper claim forms or paper claim forms in non-OCR format.

THP requires complete and accurate procedure and diagnosis codes on claims submission

including ICD-10 Z-codes to collect information about THP members' social determinants of health (SDoH).

THP encourages the submission of HCPCS Category II codes to report performance measures. Using category II codes will decrease the need for THP to request medical records.

When entering the patient information on a claim, please include the entire THP member ID number with the two-digit suffix. Do not use dashes.

THP member ID numbers begin with the letter H, then eight numeric characters, and then two- numeric suffix indicates the member type.

Suffix definitions:

- 01 – Subscriber
- 02 – Spouse
- 03 – Child (eldest)
- 04 – Child (next eldest)



Timely Filing and Timely Adjudication

For THP's Commercial Fully Insured, West Virginia Mountain Health Trust (MHT) and Medicare Advantage lines of business:

- Initial, original claims must be submitted within 180 days from the date of service.
- Corrected claims must be submitted within 180 days from the date of the original denial or within 180 days from the date of service, whichever is greater.
- Coordination of benefits (COB) claims must be submitted within 180 days from the date of service or 90 days from the date of the primary carrier's explanation of benefits (EOB), whichever is greater.

For THP's Self-Funded / Administrative Services Only customers:

- All claims must be submitted within the timely filing requirements set forth in the employer group's plan design unless otherwise required by applicable state or federal regulations.

THP will adjudicate clean claims within thirty (30) days from receipt, or as otherwise required by prompt pay requirements.

If a clean claim is not paid within the applicable timeframes, appropriate interest is applied to the claim when paid as required by state law, Medicare, or West Virginia Mountain Health Trust (MHT).

- For MHT services, interest is paid to participating practitioners at 18 eighteen percent (18%) per annum calculated daily for the full period the claim remains unpaid beyond the 30-day clean claims payment deadline.
- For Medicare Advantage services, interest is paid to participating practitioners at interest rates set by the United States Department of the Treasury at <https://www.fiscal.treasury.gov/prompt-payment/> for the full period the claim remains unpaid beyond the 30-day clean claims payment deadline.
- For Commercial Fully Insured services, interest is paid to participating practitioners at interest rates set by the United States Department of the Treasury at <https://www.fiscal.treasury.gov/prompt-payment/> for the full period the claim remains unpaid beyond the 30-day clean claims payment deadline.

THP offers Electronic Funds Transfer (EFT) at no charge for Commercial, Medicare Advantage, Mountain Health Trust (WV Medicaid & CHIP), & PEIA.

To enroll with THP's EFT, access THP's secure provider portal resource library and complete the 'EFT Enrollment Form.'

Self-funded/ Administrative Services Only (ASO) EFT will process through vendor, Optum VPay. VPay's default payment method is virtual credit card. Practitioners can update their VPay payment method by contacting VPay at 1.877.714.3222.



Practitioner Overpayments

Federal and state law requires practitioners to notify THP in writing and return the full amount of any overpayment promptly and in no less than sixty (60) days of the date on which the practitioner identifies an overpayment. This requirement applies to any payment identified as an overpayment, including those unrelated to program integrity, i.e., administrative overpayments.

In the event THP identifies an overpayment, THP will recover the full amount of the overpayment in compliance with federal and state law. Depending on factors including the coverage in which member(s) were enrolled, overpayment recoveries may be made through offset of future claims payments if a practitioner does not promptly return the amount in full.

Identification and recoupment by THP are independent of and does not relieve the practitioner's duty to identify and repay overpayments. The deadline for filing an appeal regarding a claim or payment is separate and apart from the practitioner's duty to identify and repay overpayments. Appeal rights do not toll or otherwise impact a practitioner's duty to identify and repay overpayments.

Practitioner Reconsideration (Appeal)

If a practitioner does not agree with a THP claim denial, then the practitioner has the right to file a reconsideration (appeal).

THP's practitioner reconsideration is a one-level appeal. A practitioner has the greater of 180 days from THP's original denial or 180 days from the date of service to request a reconsideration (appeal).

To file a reconsideration (appeal), practitioners can call 1.877.847.7901, fax to 740.699.6163, or mail:

The Health Plan
Attn: Appeals
1110 Main Street
Wheeling, WV 26003

Coordination of Benefits (COB)

COB is intended to avoid claims payment delays and duplication of benefits when a person is covered by two (2) 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 because of duplicate group health care coverage.



Commercial Fully Insured and Self-Funded/ASO

Each employer group contracting with THP has a COB provision in their contract. In accordance with your provider contract, claims for THP members with another insurance should be submitted to the primary carrier first for payment.

- Primary plan – plan that reviews for payment first
- Secondary plan – plan that reviews for payment second

When THP is the secondary payer, THP will adjudicate the balance of covered services not paid by the primary plan, so long as the total payment does not exceed one hundred percent (100%) of your contracted rates.

For Self-Funded/ASO members that have primary insurance from a source other than their Self-Funded/ASO plan, THP will honor utilization management decisions made by the primary carrier for those services in the primary carrier's benefit package, up to the allowed applicable contracted fee schedule limit. If THP is responsible for Self-Funded/ASO services that are carved out of the primary carrier's benefit package, THP has utilization management responsibility for those carved out services.

For members that have primary insurance from a source other than their Commercial Fully Insured plan, THP will not honor utilization management decisions made by the primary carrier for those services in the primary carrier's benefit package.

Some Commercial Fully Insured and ASO customers follow National Association of Insurance Commissioners (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% 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.



West Virginia Mountain Health Trust Members

For THP MHT members that have primary insurance coverage from a source other than Mountain Health Trust (MHT), THP will honor utilization management decisions made by the primary carrier for those services in the primary carrier's benefits package, up to the allowed WV Medicaid or WV Children's Health Insurance Program (WVCHIP) limit. If THP is responsible for West Virginia MHT, including WV Medicaid and WV CHIP services that are carved out of the primary carrier's benefit package, THP has utilization management responsibility for those carved out services.

Medicare Advantage Members

For THP Medicare Advantage members that have primary insurance from a source other than their Medicare Advantage plan, THP will honor utilization management decisions made by the primary carrier for those services in the primary carrier's benefit package, up to the allowed applicable contracted fee schedule limit. If THP is responsible for Medicare Advantage services that are carved out of the primary carrier's benefit package, THP has utilization management responsibility for those carved out services.

Benefit Order 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 (i.e., 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:

- **Employee:** The plan covering the person as an employee pays benefits first. (If the patient is THP subscriber, THP is primary.)
- **Spouse:** The plan covering that person as a dependent pays benefit second. (If the patient is the spouse of THP subscriber, THP 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 (1) 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.

COB Billing

Practitioners should bill the primary insurance first even if there is a deductible to be met so that the service can be applied to the deductible.

Practitioners should bill the secondary insurance and include the primary explanation of payment (EOP).

- o If billing electronically, COB information must be included in the electronic submission.
- o If billing on paper, a separate EOP must be submitted for each claim.

All payments indicated on the claim must be supported by an EOP or the claim will be denied.

If you receive a COB denial, please submit correct information, if applicable, based on the denial.

- For COB questions contact the COB Department at 1-800.624.6961, ext. 7903.

Members with Double THP Coverage

Practitioners should bill the copay, deductible, and/or co-insurance shown on the payment remittance by using the member's secondary ID number.

- o If billing electronically, COB information must be included in the electronic submission.
- o If billing on paper, attach a copy of the remittance showing THP's payment.



Original Medicare Primary

Any practitioner who has submitted an assigned claim to Original Medicare has agreed to accept Medicare's reasonable charge as payment in full for their services. Per the Medicare's Carriers Manual, section 3045.1, the practitioner is in violation of their signed agreement if they bill or collect from the enrollee and/or the private insurer an amount which, when added to the Medicare benefit received, exceeds the reasonable charge.

THP, as a Medicare supplemental insurer, is functioning as a private insurer. Therefore, THP will be reimbursing the physician for THP covered services when that reimbursement amount does not exceed THP's standard reimbursement.

THP will pay deductibles, co-payments, co-insurances, and other member responsibility amounts not paid by the primary carrier so long as the total payment does not exceed the amount THP would pay as the primary carrier. This process is applied to each individual service.

Original Medicare Members

Below are steps to follow when billing for a Medicare member:

1. **REGULAR MEDICARE (red, white, and blue card):** THP 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 THP at 1.800.624.6961, ext. 7903 for clarification of primary responsibility for Medicare members with this ID card.
2. **SECURECARE HMO, SNP/SECURECHOICE PPO:** Bill THP directly for all charges. THP is the Medicare carrier for Part A and Part B services.
3. **MEDICARE SUPPLEMENT:** Bill Medicare first and then bill THP for any co-insurance or deductibles (see Medicare crossover notice).

Medicare Crossover Notice

Effective as of Dates-of-Service on or after 8/29/2016

For Medicare Supplement Plans ONLY

- When your patient presents a Medicare Supplement ID card from THP, you will no longer be required to submit a claim to THP after Medicare processes the claim..
- Medicare will send THP claim information, and THP will then process the remaining copayment, co-insurance, or deductible, as applicable.
- THP will only cover those services that have been allowed or paid by Medicare. If Medicare denies the service, THP will also deny.



Documentation Submission

THP has a dedicated fax line, 740.699.6163, to submit documentation such as:

- Medical Records i.e., support an electronic claim, HEDIS, Quality Measures
- Primary Insurance Remittance/ Explanation of Payment (EOP)
- Reconsideration Request

To ensure documentation is routed correctly, please complete THP's Documentation Cover Sheet in its entirety. A copy of the cover sheet is available on THP's provider portal resource library, myplan.healthplan.org. Failure to complete the cover sheet may result in claim denials or mis-routed documentation. A separate cover sheet is required for each claim, as applicable.

All required documentation to support a claim must be faxed within twenty-four (24) hours of electronic claims transmission.

Never Events and Avoidable Hospital Conditions

Never Events

According to the National Quality Forum (NQF), never events are errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and that indicate a real problem in the safety and credibility of a healthcare facility. Never events consist of the wrong procedure being performed on the wrong body part, and/or wrong site, or on the wrong patient. 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 THP does receive claim(s) for such services, these are appropriately denied for lack of medical necessity.

Avoidable Hospital Conditions

Avoidable hospital conditions (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.

CMS identifies the following as preventable hospital acquired conditions:

- Air embolism
- Blood incompatibility
- Catheter-associated urinary tract infection
- Deep vein thrombosis and pulmonary embolism following certain orthopedic procedures.
- Falls and trauma
- Foreign objects retained after surgery



- Iatrogenic pneumothorax with venous catheterization
- Manifestations of poor glycemic control
- Mediastinitis, following coronary artery bypass graft (CABG)
- Pressure ulcers stages III and IV
- Surgical site infection following bariatric surgery for obesity
- Surgical site infection following cardiac implantable device (CEID)
- Surgical site infection following certain orthopedic procedures
- Vascular catheter-associated infection and surgical site infection

CMS requires hospitals to submit 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.

THP 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

Codes	Events	Examples
NA	Preventable	Unintended retention of a foreign object in a patient after surgery or other invasive procedure.
NB	Serious Preventable	Any death or serious injuries associated with intravascular air embolism that occurs while being cared for in a healthcare setting.
NC	Serious Preventable	Patient death or serious injury associated with unsafe administration of blood products or the administration of incompatible blood.
ND	Catheter	Urinary tract infections associated with a catheter.
ND	Pressure Ulcers	Stage III & IV (decubitus ulcers) acquired after admission/presentation to a health care setting.
NF	Vascular	Catheter associated infection
NG	Surgical Site Infection	Mediastinitis within 30 days of coronary artery bypass surgery (CABG).
NH01	Hospital-Acquired Injury	Falls and fractures
NH02	Hospital-Acquired Injury	Dislocations
NH03	Hospital-Acquired Injury	Intracranial injury
NH04	Hospital-Acquired Injury	Crushing injury
NH05	Hospital-Acquired Injury	Burns
NH06	Hospital-Acquired Injury	Other unspecified effects of external causes
NH07	Hospital-Acquired Death	Postoperative death of a healthy patient (ASA Category 1).



Codes	Events	Examples
NI	Poor Glycemic Control	Diabetic ketoacidosis, non-ketotic hyperosmolar coma, hypoglycemic coma, secondary diabetes with ketoacidosis, secondary diabetes with hyperosmolarity
NJ	Surgical Site Infection	An infectious or inflammatory reaction due to the implant of an orthopedic device following specific orthopedic procedures (spine, neck, shoulder, elbow) within 365 days.
NK	Surgical Site Infection	Surgical site infection within 30 days of bariatric surgery for obesity (laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery)
NL	DVT/PE	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.
NM	Surgery/Invasive Procedure NEVER EVENT	A surgery or invasive procedure on the wrong body part.
NN	Surgery/Invasive Procedure NEVER EVENT	A surgery or invasive procedure on the wrong patient.
NO	Surgery/Invasive Procedure NEVER EVENT	Wrong surgery/invasive procedure performed on a patient.
NP	Surgical Site Infection	Surgical site infection following a cardiac implantable electronic device (CIED).
NQ	Iatrogenic Pneumothorax	Iatrogenic pneumothorax caused by the diagnosis, manner, or treatment of a physician (i.e., inserting venous catheterization).

When any of the above variance codes are identified, a case is generated. Each case is assigned a number, and medical records are ordered for review. 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 THP. Any of the diagnoses or conditions clearly documented as present upon inpatient admission are not preventable by CMS guidelines.



Notice of Readmissions Review Occurring Within 30 Days

All clinically related /potentially preventable readmissions occurring within a thirty (30) day period are subject to review. Final review decisions are made by a THP medical director. Readmissions are denied when any of the following are determined:

- Readmission was medically unnecessary
- Readmission resulted from a prior premature discharge from the same hospital,
- Readmission resulted from a failure to have proper and adequate discharge planning OR
- Readmission resulted from a failure to have proper coordination between the inpatient and outpatient healthcare teams and/or if the readmission was the result of circumvention of the contracted rate by the hospital

Practitioners should follow these guidelines:

- Hospital readmissions within thirty (30) days for the same or similar diagnosis/DRG should be billed and paid as one (1) claim.
- The hospital should combine both inpatient admissions on one claim and bill a corrected claim.
- The index admission date should be reported.
- Combine the appropriate number of observation and inpatient days for the index admission and the readmission.
- Enter 180 (or the appropriate leave code) and appropriate service units to account for the days between the admission and the readmission when the member was not receiving services. \$0.00 should appear in "Total Charges"
- To resubmit a hospital claim electronically:
 - Indicate the original claim number in Loop 2300, Segment REF02
 - Indicate 6 (corrected claim) for the Claim Frequency Code in Loop 2300, Segment CLM05-3
- Once the corrected claim is received by THP, the index admission payment will be reversed, and the corrected claim will be reviewed and processed.

Remittance

THP distributes remittances to practitioners and facilities via USPS mail (EOP) or electronically (835) to an EDI clearinghouse, if enrolled. Each line of business generates a remittance and contains paid, denied, or recouped claims.

Chapter 4

Medical Records





Medical records are the primary source of clinical information used to support patient care and ensure continuity of care. The Health Plan (THP) requires medical records to be complete, accurate, and consistent with federal and state regulations, the National Committee for Quality Assurance (NCQA) requirements, and THP policies and procedures for all lines of business, unless otherwise noted.

Medical Records and Confidentiality Statement

The medical records and confidentiality statement ensures that a separate comprehensive medical record is created and maintained for each member. Member medical records shall include all relevant biographical and medical information to promote quality care. Medical records must be maintained in a confidential manner.

All participating practitioners shall maintain a current member medical record in accordance with THP standards for member records and in compliance with all federal and state laws and regulations.

All practitioners shall preserve all records related to members for a period of not less than ten (10) years, longer if the records are under review or audit.

Medical records shall be made available, as required, to each practitioner treating the member. Medical records must be made available or provided upon request to an authorized representative of THP and to appropriate state and federal authorities, or their delegates, for medical record audit, quality improvement activities and initiatives, utilization review, investigation of member grievances or complaints, fiscal audit, program integrity review including pre- or post-payment review, and other regulatory auditing or monitoring initiatives.

Medical records and member information should only be accessed by the appropriate personnel as necessary to complete required job functions. All medical records and member identifying information are subject to the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and should be treated as such.

Medical Records Request and Review

THP conducts pre- and post-payment medical record reviews. Practitioners may receive a medical records request for care delivered to THP members. Practitioners are required to provide records securely, in a timely manner, and at no cost to THP unless otherwise specified in the practitioner agreement. The record request may come directly from THP or an organization conducting a review on THP's behalf. Medical records should be submitted with a copy of the original request to ensure proper processing.

If a response timeframe is not stated in the medical record request, records must be provided within 30 calendar days from the date of the request. Practitioners should notify the requester regarding extension requests. Failure to provide the requested records within the required timeframe may result in claim denial or other adverse actions, including termination from THP's network.

Practitioners who submit medical records that do not meet medical record requirements and standards are notified of the audit findings and provided educational resources. As applicable, the practitioner will be required to submit a corrective action plan and may be subject to additional pre- or post-payment reviews.



Standards for Medical Records

1. Identification, Care, and History

Each medical record entry must be specific to a single, clearly identified, and named member and the services rendered by the practitioner(s). Medical records should contain the following, as applicable:

- All information needed to conduct utilization review or support services billed;
- Member identification information, including name and/or identification number on each page or electronic file;
- Personal/biographical data, including age, sex, address, employer, home and work phone numbers, and marital status;
- Date of entry and/or service date;
- Practitioner identification (including credentials) for all practitioner(s) involved in the specific episode of care;
- A list of allergies, when appropriate for the service type;
- Past medical history;
- Completed immunization record or notation for members aged 12 and under to indicate immunizations are up-to-date and when subsequent immunizations are required, as appropriate for service type;
- Diagnostic information;
- Medication information;
- Identification of current problems, including significant illness, medical conditions, and health maintenance concerns;
- Smoking/ethanol/substance use notations (as appropriate) concerning cigarette and alcohol use and substance use (if present) for members 14 years of age and over and when seen three (3) or more times;
- Consultations, referrals, and specialist reports, including notes from consultations, lab reports, and x-ray reports with the ordering practitioner's initials or other documentation signifying review, such as an explicit notation in the record and follow-up plans for significantly abnormal lab and imaging study results;
- Documentation of emergency care provided;
- Hospital discharge summaries for hospital admissions including prior admissions and admissions that occur while the member is enrolled in the plan;
- Advance directives, including documentation of whether the member has executed an advance directive;
- Visit data for each individual encounter, including adequate evidence of the following:
 - History and physical examination, including appropriate subjective and objective information for the presenting complaint
 - Plan of treatment
 - Diagnostic testing
 - Therapies and other prescribed regimens
 - Follow-up activities, including encounter forms with notations concerning follow-up care or visits, with return times noted in weeks, months, or as needed, and documentation demonstrating unresolved problems were addressed at subsequent visits
 - All other aspects of care, including ancillary services



2. Legibility

Medical records must be legible and understandable to someone other than the writer. Any record judged as illegible will be evaluated by a second reviewer. If both reviewers are unable to read the record, it will be deemed “illegible” and may result in claim denial or other appropriate action, depending on the reason(s) for review.

3. Stand Alone

Medical records submitted to support a claim must “stand-alone”, meaning only information necessary to support the services and diagnoses billed are included. References to other records are acceptable, but only if the referenced records are also provided for review and support the medical necessity of the service(s) billed. For example, if the treating practitioner refers to the goals and objectives of the member’s treatment plan to provide context to the issues addressed in the visit, the treatment plan should be included in the documentation provided for review.

4. Signatures

Medical records must be appropriately signed by the individual practitioner who rendered the services, including the individual’s professional credentials and date and time of signature. Signatures may be handwritten, initials over a typed or printed name, or authenticated electronically. If a signature is handwritten and illegible, it must be accompanied by a typed or printed copy of the practitioner’s signature including their professional credentials.

Electronic signatures must include a date and time and the practitioner’s name and credentials. Signature stamps are not acceptable, except when needed to accommodate a physical disability.

Practitioners may include a signature log in their medical record submissions that includes the typed or printed full name of the practitioner(s) who rendered the services and their professional credentials. The practitioner’s title or role may be used in lieu of credentials, as applicable.

a. Supervisory Signatures

The signature of supervisory personnel indicates their review and approval of the documentation. Supervisory personnel signatures must be included when appropriate or required to substantiate rendered services.

b. Signature Timeliness

The Centers for Medicare and Medicaid Services (CMS) require that medical records be signed “as soon as practicable after the service is provided to maintain an accurate medical record.”

THP follows CMS’ guidelines for signature requirements unless preempted by another authority such as the West Virginia Bureau for Medical Services (WV BMS) Provider Manual. THP defines “as soon as practicable” to mean:



A time reasonable, upon completion of the service, for the practitioner to sign the documentation as complete and accurate, not to exceed five (5) business days or seven (7) calendar days, unless the reason for delay is specifically noted in the individual medical record. The signature of a supervisor, when required, must be made within five (5) business days of the signature of the individual being supervised.

Documentation may not be signed in advance of the service being rendered and must be completed prior to submitting a claim. Exceptions may be considered if justified within the medical record or through a properly documented addendum or attestation.

c. Orders for Services

Medical records for the following services must contain an order signed by an appropriately qualified individual:

- Testing, e.g., routine, diagnostic, genetic;
- Admission to a facility, program, or course of treatment that requires a qualified medical practitioner order; and
- Durable Medical Equipment, Prosthetics, Orthotics, Supplies

5. Time-Based Services

Services that are time-based (billable by unit for a specific amount of time spent rendering the service) must include the duration of the service in start and stop times, as applicable or required by the service billed.

Evaluation and Management Services

Medical records for evaluation and management (E&M) services must be individualized and include the member's health history, care, findings, and observations including the following as applicable:

- Billed procedure code components
- Time the practitioner spent with the member and/or the number and complexity of problems addressed during the encounter
- Reason for the encounter and the relevant history, findings of the physical examination, and prior test results
- Assessment and diagnosis
- Comorbidities and/or risk of mortality
- Treatment Plan

The WV BMS Provider Manual Chapter 519 "Practitioner Services" for Mountain Health Trust (WV Medicaid and CHIP) requires documentation of time the practitioner spent with the member for medical decision making (MDM), even if the level supported is based on MDM rather than time.



Use of Imagery

The inclusion of images, (e.g., photographs, x-rays, scans), in medical records are encouraged when available and must be clearly labeled to include:

- Member name;
- Date the image was obtained;
- Anatomical location of image or indication of view; and
- Relevant scale, if applicable

Telehealth Services

Telehealth medical records must meet the same requirements and standards as those for an in-person visit.

The member's consent to receive treatment through telehealth must be obtained verbally or in writing. If the consent is obtained verbally, it must be documented in the record. The consent may be included in the member's initial general consent for treatment or documented in the medical record for each telehealth visit.

The audio, video, or computer telehealth system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through telehealth. The telecommunication equipment must be of a quality sufficient to complete all necessary components of the services rendered. For example, if a peripheral diagnostic scope is required to assess the member, it must provide adequate resolution or audio quality to support medical decision making.

Medical records must include the mode of communication used for the telehealth service. Electronic mail messages, e.g., email, SMS text messaging, facsimile, may be documented in the medical record but may not be billed for reimbursement.

The location of both the practitioner and member must be documented in the medical record to support place of service billed. If the practitioner has more than one office location, the address of the telehealth encounter should be included.

The practitioner at the distant site is responsible for maintaining the standards of care within their scope of practice.

Drug Screenings

Medical records must clearly state the medical necessity of drug test(s) ordered and include drug name, diagnoses, and reason for the encounter. Test results, specific findings, and the practitioner's actions in response to the results should be included. A nonspecific or unspecified diagnosis does not satisfy the requirement for drug testing.

Point of care testing refers to testing completed in the practitioner's office and must have an order, prior authorization (if required), or plan indicating testing was ordered and performed. This documentation must be included within the signed encounter note and include all findings, whether included in the same note, an addendum, or an additional progress note.

Routine reflex testing is not a covered service for Mountain Health Trust (WV Medicaid and CHIP) members. Reflex testing occurs when an initial result meets pre-determined criteria, and an additional test is performed automatically based on the pre-determined criteria without a separate order from the treating practitioner.



Altered, Amended, or Addended Records

Once medical records are created, they cannot be altered. Corrections or amendments may be made if the original documentation remains and is clearly marked as corrected or amended. Practitioners may not write over, white-out, delete, or erase a prior entry. The correction or amendment should be marked through with a straight line, initialed, dated, and followed by the updated information.

Electronic medical records must clearly identify the original documentation and the correction or amendment with the date, time of correction/amendment, identity of the individual making the correction/amendment, and reason(s) for the correction/amendment. Printed electronic medical records must also include this information.

Addenda may be made only when the correct information was not available at the time of the original documentation. Exceptions may be made for entries that are inadvertently entered into an incorrect member file. At a minimum, an addendum must include:

- A statement indicating that the entry is an addendum;
- The date and time the record was addended;
- The details of the addended information; and
- The signature of the practitioner writing the addendum.

Practitioners may not create a new separate entry to replace an existing entry in lieu of adding an addendum.

Templated, Copy-and-Paste, or Replicated Records

Each medical record must be specific to the individual service and member. Medical record templates must include evidence that individual treatment was provided, even in group settings. An individual with knowledge and/or experience in a relevant field reviewing the medical record must be provided with sufficient information in the medical record to support an understanding of the member's current condition and services provided.

Documentation that is copied-and-pasted (replicated) from one visit to the next or from one member to another member is prohibited. Replicated records do not support services billed.

Medical record documentation can be carried forward only if accompanied by dated and signed documentation updating the member's status individually, as described above.

The practitioner may add an explanation in the medical record for any medical record anomalies.

Electronic Health Records (EHR)

Practitioners utilizing EHRs should maintain policies and procedures to:

- Prevent loss or destruction of the EHR.
- Promote secure electronic exchange of member information when authorized.
- Avoid creation of replicated documentation.
- Ensure each entry in the EHR includes proper validation, including the practitioner's name, credentials, date, time, and source of data.



- Verify the validity of auto-populated information. Auto-populated information is data that does not require positive action or is the result of abbreviated words or keystrokes.
- Prevent fraud, waste, and abuse for practitioners utilizing e-prescribing.
- Where allowable by law, ensure documentation created by artificial intelligence (AI) is clearly denoted as such and is reviewed for accuracy and verified by a human signatory. If AI is used, it must be HIPAA-compliant.
- If templates are used, the material entered must be individualized and relevant to the presenting problem(s) and service(s) provided during that encounter.
- Accommodate the identification and signatures of multiple individuals so that the author of each entry in the record is clearly identified.



Common Coding Scenarios

1. History vs. Active – Congestive Heart Failure (CHF)
 - **What was documented:** "Patient has a history of CHF. Compensated on home regimen. Continue furosemide 40mg daily, metoprolol succinate 50mg daily, and spironolactone 25mg daily."
 - **What was coded:** Z86.79 — Personal history of other diseases
 - **The problem:** "History of" implies the condition is resolved and no longer exists. However, this patient is on three (3) daily medications specifically for heart failure management. CHF is actively managed, not a resolved condition. If a patient requires ongoing medication, monitoring, or treatment for a chronic condition, it is active, not a history of.
 - **What should be coded:**
 - **I50.9** — Heart failure, unspecified (*at minimum*)
 - **I50.22** — Chronic systolic heart failure (*if EF documented as reduced*)
 - **I50.32** — Chronic diastolic heart failure (*if EF preserved and documented as diastolic*)
 - **I50.42** — Chronic combined systolic and diastolic heart failure (*if both documented*)
2. Missed Specificity – Heart Failure Type
 - **What was documented:** "Chronic systolic heart failure, ejection fraction 35-40%, NYHA Class II symptoms. Stable on current regimen."
 - **What was coded:** I50.9 — Heart failure, unspecified
 - **The problem:** The practitioner explicitly documented "systolic heart failure" and gave an ejection fraction. ICD10-CM has distinct codes for systolic, diastolic, and combined heart failure. Coding to I50.9 ignores clinical specificity that affects patient severity profiles.
 - **What should be coded:** I50.22 — Chronic systolic heart failure (*specific to documented type*) or, if documented:

Description	Code
"Acute on chronic systolic HF"	I50.23
"Diastolic HF, EF > 50%"	I50.32
"Acute on chronic diastolic HF"	I50.33
"Combined systolic and diastolic HF"	I50.42
"Acute on chronic combined HF"	I50.43

Chapter 5

Commercial
Fully Insured and
Self-Insured/
Administrative
Services Only





Commercial Health Maintenance Organization (HMO) Plans

Commercial health maintenance organization (HMO) plans are fully insured by a Health Insuring Corporation (HIC). Employer groups contract with THP and pay a monthly premium to provide a health insurance benefit plan to eligible employees. THP is responsible for providing the benefit package, administering all aspects of the plan, and assuming the risk of paying for all covered services. These plans require a member to choose a primary care practitioner (PCP), obtain a referral from their chosen PCP and follow all prior authorization guidelines. Members do not have out-of-network benefits unless authorized by the plan.

HMO benefit plans generally have copays for:

- Primary and specialty care practitioner 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 (2) employees, contract with THP and pay a monthly premium to provide a health insurance benefit plan to eligible employees.

POS plans are designed to allow members the freedom to choose between having their health care managed or arranged by their PCP as an in-plan option or having their health care arranged 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 practitioner 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 THP 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 practitioner office visits
- Emergency room services
- Urgent care
- Outpatient mental health
- Physical, occupational, and speech therapy
- Durable medical equipment
- Biotech drugs

Members are responsible for deductibles and co-insurance amounts associated with their plan benefit.



Commercial Preferred Practitioner Organization (PPO) Plans

Commercial preferred practitioner organization (PPO) plans are fully insured by a Health Insuring Corporation (HIC). Members who are covered under the PPO plan generally are not required to select a PCP or obtain a referral for specialty practitioner services. All prior authorization guidelines apply. By utilizing THP's network, members receive a higher level of benefits. Members who utilize out-of-network practitioners or fail to prior authorize 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 practitioner office visits
- Emergency room services
- Urgent care
- Outpatient mental health benefits
- Physical, occupational, and speech therapy
- Durable medical equipment
- BioTech drugs

Members are responsible for deductibles and co-insurance amounts associated with their benefit plan.



Sample Commercial Member ID Cards

This card is issued to members enrolled in a Commercial (including Health Maintenance Organization [HMO], Preferred Practitioner Option [PPO] and Point of Service [POS]) plan. This includes WV State employees who are covered by the Public Employees Insurance Agency (PEIA) plan.

Commercial WV Sample ID Card

FRONT

MEMBER

Group #:
JOHN SAMPLE
ID: SMPL0001

COVERED INDIVIDUALS

SMPL0001 01 JOHN SAMPLE
SMPL0001 JANE SAMPLE
SMPL0001 JIMMY SAMPLE

BENEFIT INFORMATION

EFF DATE:
DED: IN
DED: OUT
OOPM: IN
OOPM: OUT

PHARMACY PLAN

RxBIN: 610014
PCN:
Grp:
Issuer: 9151014609 (80840)
Members: 1.800.624.6961, ext 7914 (TTY: 711)
Visit healthplan.org
Pharmacists Only: 1.800.922.1557, 24/7

www.healthplan.org

BACK

CLAIM SUBMISSION

PROVIDERS: Call 1.877.847.7901

Mail Claims To:
The HealthPlan
1110 Main Street
Wheeling, WV 26003 EDI: 95677
Or visit: myplan.healthplan.org

MEMBER SERVICES

Member Services/Emergencies:
1.888.847.7902 (TTY: 711)
Mental Health/Substance Abuse Assistance:
1.877.221.9295
Healthiest You: 1.866.703.1259

Please visit us at healthplan.org.

This card does not guarantee coverage. Visit our website to verify benefits or view claims. Call for notification or pre-authorization.

Fraud Hotline: 1.877.296.7283

Commercial Ohio Sample ID Card

FRONT

MEMBER

Group #:
JOHN SAMPLE
ID: SMPL0001

COVERED INDIVIDUALS

SMPL0001 01 JOHN SAMPLE
SMPL0001 JANE SAMPLE
SMPL0001 JIMMY SAMPLE

BENEFIT INFORMATION

EFF DATE:
DED: IN
DED: OUT
OOPM: IN
OOPM: OUT

PHARMACY PLAN

RxBIN: 610014
PCN:
Grp: 3602
Issuer: 9151014609 (80840)
Members: 1.800.624.6961, ext 7914 (TTY: 711)
Visit healthplan.org
Pharmacists Only: 1.800.922.1557, 24/7

www.healthplan.org

BACK

CLAIM SUBMISSION

PROVIDERS: Call 1.877.847.7901

Mail Claims To:
The HealthPlan
1110 Main Street
Wheeling, WV 26003 EDI: 95677
Or visit: myplan.healthplan.org

MEMBER SERVICES

Member Services/Emergencies:
1.888.847.7902 (TTY: 711)
Mental Health/Substance Abuse Assistance:
1.877.221.9295
Healthiest You: 1.866.703.1259

Please visit us at healthplan.org.

This card does not guarantee coverage. Visit our website to verify benefits or view claims. Call for notification or pre-authorization.

Fraud Hotline: 1.877.296.7283



Self-Funded / Administrative Services Only (ASO) Employer Groups

Employers may choose to pay claims as they are incurred, rather than pay a monthly premium for their employees' medical benefits. THP offers administrative services only (ASO) plans to assist these employers with administering their benefit plan. The plan offers them a contracted network of practitioners, 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 THP. ASO plan benefits, copays, deductibles, and ID cards may vary from the standard insured plans offered by THP.

Sample Self-Funded/ASO ID Cards

This card is issued to members who are enrolled in a Self-Funded plan. The employer's name will differ on these cards (as shown on the front of the card).

Note: Services requiring prior authorization may differ by plan. Contact THP to confirm benefits.

Self-Funded/ASO Sample ID Card

FRONT	BACK
 MEMBER Group #: JOHN SAMPLE ID: SMPL0001 EFF: BENEFIT INFORMATION DED: IN DED: OUT OOPM: IN OOPM: OUT COVERED INDIVIDUALS SMPL0001 01 JOHN SAMPLE SMPL0001 JANE SAMPLE SMPL0001 JIMMY SAMPLE GROUP LOGO www.healthplan.org	CLAIM SUBMISSION Providers: 1.888.816.3096 Claims: The Health Plan 1110 Main Street Wheeling, WV 26003 EDI: 95677 Or visit: myplan.healthplan.org MEMBER SERVICES Member Services/Emergencies: 1.888.816.3096 (TTY: 711) Mental Health/Substance Abuse Assistance: 1.877.221.9295 Please visit us at healthplan.org. This card does not guarantee coverage. Visit our website to verify benefits or view claims. Call for notification or pre-authorization. PHARMACY PLAN RxBIN: 610014 RxPCN: RxGRP: Issuer: 9151014609 (80840) Members: 1.800.624.6961, ext 7914 (TTY: 711) Visit healthplan.org Pharmacists Only: 1.800.922.1557, 24/7 Fraud Hotline: 1.877.296.7283

Self-Funded/ASO Reference Based Pricing (RBP) Sample ID Card

FRONT	BACK
MEMBER JOHN SAMPLE ID: SMPL0001 Group #: EFF: DED: IN DED: OUT OOPM: IN OOPM: OUT COVERED INDIVIDUALS SMPL0001 01 JOHN SAMPLE SMPL0001 JANE SAMPLE SMPL0001 JIMMY SAMPLE MEDICAL NETWORK   Practitioner & Ancillary Only Providers are reimbursed pursuant to the terms of the plan document up to the Reasonable/Allowable amount (subject to reference pricing). Only physician and ancillary (applicable) services may be subject to a PHCS network. The plan will only consider an assignment of benefits valid under the condition that the provider accepts the payment requested as compensation in full for the network, supplies and/or treatment rendered, less any required copayations. To locate a PHCS provider: www.multiplan.com/VDHP 1.866.416.6488 PHARMACY PLAN RxBIN: 610014 RxPCN: RxGRP: 3602 Issuer: 9151014609 (80840) EXAMPLE	CLAIMS SUBMISSION Providers: 1.888.816.3096 Claims: The Health Plan 1110 Main Street Wheeling, WV 26003 EDI: 95677 Or visit: myplan.healthplan.org MEMBER SERVICES Member Services: 1.888.816.3096 (TTY: 711) Mental Health/Substance Abuse Assistance: 1.877.221.9295 Please visit us at healthplan.org. This card does not guarantee coverage. Visit our website to verify benefits or view claims. Call for notification or pre-authorization. OTHER INFORMATION Assignment of Benefits (AOB) is a waiver of the Provider's right to balance bill the patient. For non-contracted providers, depositing checks received from the Plan represents accord and satisfaction. Please see the Plan Document or contact The Health Plan at 1.888.816.3096. Fraud Hotline: 1.877.296.7283



Vision Service Benefits

Members enrolled through THP Commercial programs may also have vision benefits. Superior Vision administers vision benefits for Commercial members. Please contact Superior Vision for information on benefits and coverage under these vision plans.

THP offers benefit riders for vision benefits administered through Superior Vision for Commercial members. Practitioners must be participating with Superior Vision before offering covered vision services to members.

Supervisor Vision can be contacted at <https://superiorvision.com/contact/>

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

Members may require ophthalmologic medical services in conjunction with medical condition(s). These medical services must be offered through a THP contracted and credentialed ophthalmologist or optometrist. A referral from the PCP may be required for the member to obtain medical services from an ophthalmologist or optometrist.

Vision Billing

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 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 available through THP's vision benefit vendors, provided you are a participating practitioner.

The visit should be billed to THP as an 837p (professional) claim with the following codes:

92002, 92004, 92012, or 92014	Eye exam, new or established patient
92015	Determination of refractive state

After THP 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 THP's vision practitioner (if you are a participating practitioner) for payment of the refraction.

Please include THP's payment remittance when submitting to Superior Vision for the remaining portion.

Superior Vision will coordinate benefits with THP 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 a plan that is not associated with THP, you may also submit a claim for the refraction to that plan and they will adjudicate the claim according to their plan guidelines.

- THP encourages its 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 completed during the visit, the office copayment is waived.



THP's Members' Rights and Responsibilities Statement

Statement of Members' Rights

- Members have the right to receive information regarding the plan. This includes information such as a summary of the plan's accreditation report and the plan's services, policies, benefits, limitations, practitioners, and practitioners. Members have the right to information on member rights and responsibilities as well as any charges they may be responsible for. Members have the right to obtain evidence of medical credentials of a plan practitioner, (i.e., diplomas and board certifications). If a member needs assistance with any of the above, they may contact THP'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, practitioners and their staff will respect members' privacy.
- All information concerning THP member's medical history and enrollment file is confidential. The member has a right to approve or refuse the release of personal information by THP except when the release is required by law. THP assures that all patient information is held in the strictest confidence. All staff must adhere to THP 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 practitioner (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 THP are encouraged to establish a relationship with their chosen PCP so that they can work together to maintain good health. Members of THP may change practitioners once per calendar month if so desired (depending upon the availability of the chosen practitioner).
- THP members have the right to express their comments, opinions or complaints about THP or the care provided and to file a grievance for an administrative or medical complaint and hearing procedures without reprisal from THP. Members also have the right to have coverage denials reviewed by the appropriate medical professionals consistent with THP review procedures. Both informal and formal steps are available to members to resolve all complaints/grievances.
- THP members may participate in decision-making about their health care when possible and within the plan guidelines. Members have a right to discuss with practitioners, without limitations or restrictions being placed upon the practitioners, 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.
- THP 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 THP through yearly member satisfaction surveys, telephone calls from our members, by email to: information@healthplan.org or through our corporate website, healthplan.org. Member's comments/opinions are also received through various departments at THP.



- Members have the right to full disclosure, from their health care practitioner, 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 THP Customer Service Department at 1.888.847.7902.

Statement of Members' Responsibilities

- A member must choose a PCP for each person listed on THP ID card. The member has a responsibility to maintain a relationship with a PCP, as the PCP will act as the coordinator for all their health care needs.
- A member must identify themselves as a member of THP 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 (outreach calls are only to Commercial members, not ASO), 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 THP for assistance, if necessary.
- A member is required to notify THP 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 PCP
- Members are asked to be on time for appointments and to call the practitioner's office promptly if an appointment cannot be kept.
- Members must provide necessary information to the practitioners rendering care. Such information is necessary for the proper diagnosis and/or treatment of potential or existing conditions.
- Members must 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 the practitioners who deliver health care services.
- If members receive emergency care outside THP's service area, they are required to contact THP as soon as possible within 48 hours.
- Members must contact their PCP, secondary care practitioner, or OB/GYN before seeking any specialty practitioner/service.
- Members must provide THP with all relevant, correct information and pay THP 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 THP employees and practitioners. The THP member handbook is the primary source of information regarding their benefits.

THP member handbook is available upon request by the member.



Member Copayments, Co-insurance & Deductibles

THP offers benefit plans requiring member responsibility 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, and deductibles. As groups re-enroll annually, the member copayment may change, depending upon the plan selected by the employer. A practitioner should not collect more than the amount that is the member's responsibility as a copayment, coinsurance and/or deductible.

Copayments

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. Copays are the member's responsibility and are expected to be paid at the time of service.

It is imperative that practitioner offices ask for the member's ID card at every visit. A sample of THP ID cards are shown on the product matrix located in **Chapter 2 – Product Information**.

Member copayments for practitioner office visits and certain other services can be found on THP's practitioner secure portal at myplan.healthplan.org

Copays may not be waived; this is a practitioner contract violation.

Copays do not apply to hospital inpatient practitioner visits, preventive services, prenatal office visits (after the initial visit), practitioner 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.

Collecting copayments when another insurance is primary

If you have questions regarding whether to collect an office copay, please contact THP Coordination of Benefits (COB) Department at 1.800.624.6961, ext. 7903, or refer to the secure practitioner portal's 'Search Patients' tool at myplan.healthplan.org.



Co-insurance

Co-insurance is an amount based upon the member being responsible for a percentage of the allowed amount for a covered service. A practitioner may request co-insurance payment at the time of service; however, the practitioner must determine the member's specific benefit and apply any contract reimbursement terms to determine the amount of the co-insurance.

THP suggests practitioners wait until payment remittance is received where member responsibility is indicated. A copy of the remittance is 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 practitioner may expect payment from the member at the time of service if the member has not satisfied their annual deductible. Unless the member knows that they have not met their deductible, it may be difficult to determine how much of the annual deductible has been met at the time of service.

Affordable Care Act and Member Responsibility

The Affordable Care Act (ACA) requires private insurers to cover certain preventive services without any patient cost-sharing. THP products affected by the ACA are 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 members receiving these services. As a reminder, annual well exams and other preventive services may not require a copay or co-insurance from the member.

At no time should a practitioner collect more than the amount that is the member's responsibility as a copayment, coinsurance and/or deductible.

Chapter 6

Mountain Health
Trust (MHT)





Mountain Health Trust (MHT) Program

The Mountain Health Trust (MHT) program includes West Virginia (WV) Medicaid which includes Temporary Assistance for Needy Families (TANF), Expansion, and Supplemental Security (SSI), the West Virginia Children's Health Insurance Program (WVCHIP) membership.

THP began administering health care benefits to WV Medicaid Members on September 1, 1996, and WVCHIP members on January 1, 2021. THP currently serves MHT members in all 55 West Virginia counties. THP will notify practitioners at least thirty (30) days in advance of WV Bureau of Medical Services (BMS) and/or MHT program changes.

Mountain Health Trust Member ID Cards and Member Eligibility

The member is expected to present both their THP card and Medicaid card (8.5"x11" eligibility form) when receiving services. Each eligible individual family member will have a separate ID card with their own ID number. THP member ID card has the applicable program logo and important information including:

- Member's plan ID # including 01 suffix (the "H" and suffix must be included when submitting claims)
- West Virginia Department of Human Services (WVDoHS) assigned member ID number
- Member's name
- Member's Primary Care Practitioner (PCP) name
- PCP phone number

All members, except newborns, become effective on the first of each month and become terminated on the last day of the month. To verify member eligibility please visit THP's secure [practitioner portal](#) or call the Customer Service Department at 1.888.613.8385.

When medically necessary, practitioners are required to make services available 24 hours a day, seven days a week. Practitioners must comply with the access standards set forth in **Chapter 11 - Quality** of the practitioner manual.

THP must cover a member's out-of-network services covered under the MHT if THP's practitioner network is unable to provide those services. THP will ensure the member's cost is no greater than if the services were rendered within THP's practitioner network. Out-of-network services must be covered as adequately and as timely as if those services were provided within THP's practitioner network, and for as long as THP practitioner network is unable to provide the service.

THP must ensure that services are provided in a culturally competent manner to all members, including those with limited English proficiency and/or limited 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 THP practitioner network offers MHT members with physical and/or mental disabilities physical access, reasonable accommodation for physical access, and accessible equipment.

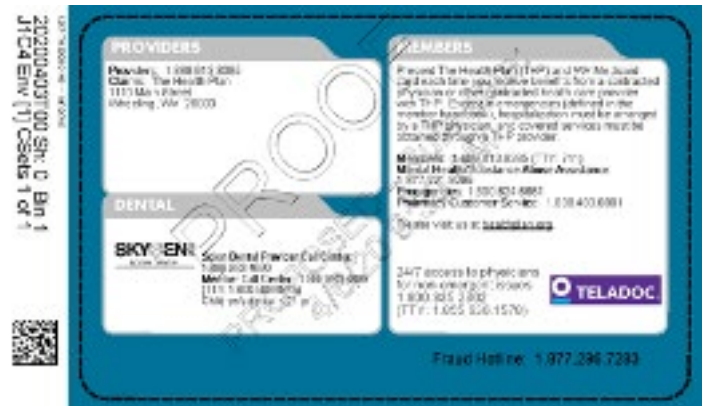
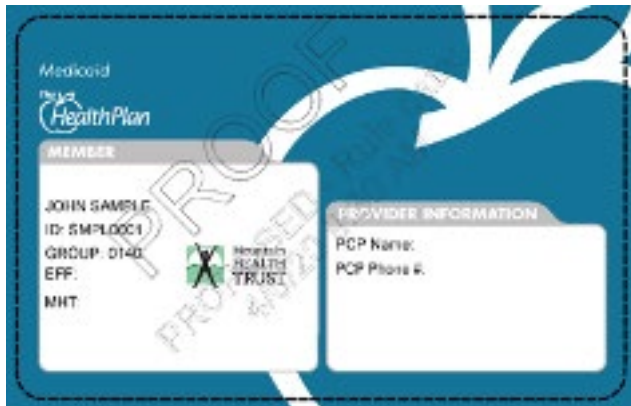


Sample Mountain Health Trust Member ID Cards

THP Medicaid member ID cards are color-coded blue to more easily identify THP's Medicaid population. If you have any questions, please contact THP Customer Service Department at 1.888.613.8385.

WV Medicaid

Group number: 0140, 0141 and 0142

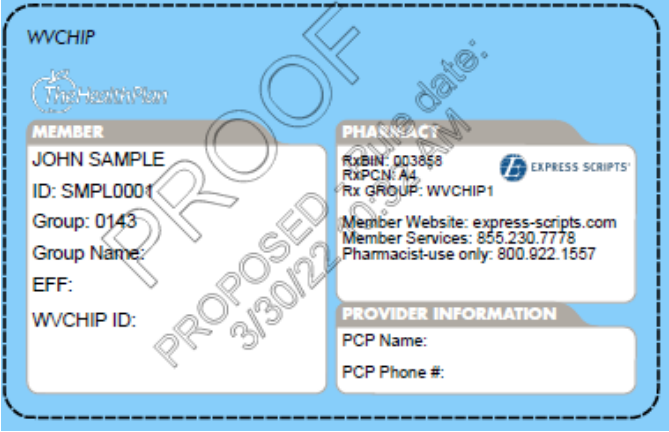




WV CHIP

THP WVCHIP cards are color-coded light blue to more easily identify the WVCHIP population. If you have any questions, please contact THP Customer Service Department at 1.888.613.8385.

Front:



Back:





Medicaid Benefits and Exclusions at a Glance

Benefit packages differ, depending on the member's age and whether the member is covered under Mountain Health Trust.

Mountain Health Trust Covered Benefits
<u>Medical</u> • Primary Care/Specialist Office Visits/FQHC/RHC– Includes practitioner and nurse midwife services. • Practitioner Services– Certain services may require prior authorization or have service limits. May be delivered through telehealth. • Laboratory and X-ray Services– Includes lab services related to substance abuse treatment. Services must be ordered by a practitioner and certain procedures have service limits. Genetic testing requires prior authorization. • Clinics– Includes general clinics, birthing centers, and health department clinics. Vaccinations are included for children. • Private Duty Nursing – For children ages 0-21, Requires prior authorization. Limits apply.
<u>Hospital</u> • Inpatient– Includes all inpatient services (including bariatric and corneal transplants). Transplant services must be in a center approved by Medicare and Medicaid and covered under fee-for-service. Some behavioral health inpatient stays are not included. Requires prior authorization. • Organ and Tissue Transplants– Corneal and stem cell transplants only. • Outpatient– Includes preventative, diagnostic, therapeutic, all emergency services, and rehabilitative medical services.
<u>Ambulatory Surgical Care</u> • Includes services and equipment for surgical procedures.
<u>Emergency</u> • Post-stabilization– Includes care after an emergency health condition is under control. Care provided in a hospital or other setting. • Emergency Transportation– Includes ambulance and air ambulance. Out-of-state requires prior authorization.
<u>Rehabilitation</u> • 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. • 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. • 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). Requires prior authorization.



Mountain Health Trust Covered Benefits

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. Any chiropractor properly qualified may engage in the use of physiotherapeutic devices, physiotherapeutic modalities, physical therapy and physical therapy techniques. Chiropractic, physical therapy (PT), occupational therapy (OT), and osteopathic manipulation are permitted when performed by a chiropractor for chronic pain management. Coverage is limited to (20) chiro/PT/OT/osteopathic manipulation combined visits per qualifying event (e.g., broken arm).
- 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 a 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 12-month postpartum 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. Sterilizations are not covered for enrollees under age twenty-one (21), for enrollees in institutions, or for those who are mentally incompetent. Services may be accessed by in network or out of network practitioners.
- Maternity Care—Includes prenatal, inpatient hospital stays during delivery, and postpartum care. Home birth is not covered.



Mountain Health Trust Covered Benefits

Durable Medical Equipment, Orthotics and Prosthetics

- Devices and medical equipment prescribed by a practitioner to ameliorate disease, illness or injury. Certain procedures have service limits or need prior authorization. Customized special equipment considered.
- Requires prior authorization and must meet THP guidelines.
- Limited replacements.
- Other limitations may apply.

Hospice

Requires prior authorization for inpatient hospice. If the member revokes three times, the member is no longer eligible for hospice. For adults, rights are waived to other Medicaid services related to the terminal illness.

Home Health Care

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 is not required.

Dental

- For children (ages 0-21)
 - Must use participating practitioners (see practitioner directory or call Skygen Dental, 1.888.983.4698).
 - Orthodontics covered for the entire duration of treatment regardless of loss of eligibility. Requires prior authorization.
- For adults (21 and older)
 - Must use participating practitioners (see practitioner directory or call Skygen Dental, 1.888.983.4698).
 - Accident or injury, tumor removal, or emergency extraction
 - \$2,000 benefit for preventive and restorative care, such as cleanings and crowns, every two years
 - TMJ is not covered for adults.

Vision

- For children (ages 0-21)
 - Must use participating vision services practitioners. See practitioner 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.

Diabetes Management

- Members diagnosed with diabetes have the right to access vision services without a PCP referral for an annual examination.



Mountain Health Trust Covered Benefits

Hearing

- For children (ages 0–21)
 - Audiology screening/testing does not require authorization (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 or devices 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 for functional testing for specific medical conditions.
 - Hearing aid evaluations, hearing aid supplies, batteries, and repairs are not covered for members aged 21 and older.

Behavioral Health

- Behavioral Health Rehabilitation/Psychiatric Residential Treatment Facility – Includes services for children and adults with mental illness and substance abuse. Limits frequency and amount of services. Certain services require pre-authorization.
- Inpatient Psychiatric Services – Includes treatment through an individual plan of care including post-discharge plans for aftercare. Service is expected to improve the condition or prevent regression so the service will no longer be needed.
 - Under age 21 – Includes services at a psychiatric hospital or psychiatric unit of a hospital. Certification required. Pre-admission and continued stay prior authorization is required.
 - Age 21 to 64 – Includes treatment at an Institution for Mental Diseases (IMD).
- Outpatient – Includes services for individuals with mental illness and substance abuse. Some services may have frequency and unit limits that require authorization beyond initial service (e.g. Assertive Community Treatment[ACT]). ACT Team must be ACT certified. Certain services require pre-authorization.
- Psychological Testing – Some psychological testing may be delivered using telehealth. Some evaluation and testing procedures have frequency restrictions. Certain services require pre-authorization.
- Drug Screening – Laboratory services to screen for presence of one or more drugs of use. Limits apply and pre-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. Some services may require an authorization once defined limit is reached.

Gender Affirmation Surgery

- Procedure that aligns an individual's biological sex with their gender identity. Adults must be twenty-one (21) years or older prior to being considered for the procedure. Prior authorization is required.

Abortion

- Includes drugs or devices to prevent implantation of the fertilized ovum and procedures for termination of ectopic pregnancy. Practitioner certification required. All Federal and State laws regarding this benefit apply.



Benefits Under Fee-for-Service Medicaid (For more information on fee-for-service benefits, visit <https://bms.wv.gov>)

Early Intervention Services for Children Three and Under

- Includes services and supports provided through the West Virginia Birth to Three program for children under age three (3) who have a delay in their development, or may be at risk of having a delay, and for their families.

Nursing Facility Services

- Includes nursing, social services, and therapy.

Personal Care Services

- Includes personal hygiene, dressing, feeding, nutrition, environmental support, and health-related functions. Room and board services require practitioner certification. May not exceed 60 hours per month without prior authorization.

Personal Care for Aged/Disabled

- 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 practitioner order and nursing plan of care.

ICF/MR Intermediate Care Facility

- Includes practitioner and nursing services, dental, vision, hearing, lab, dietary, recreational, social services, psychological, habilitation, and active treatment for the mentally retarded. Requires practitioner or psychiatrist certification.

Prescription Drugs

- Includes dispensed on an ambulatory basis by a pharmacy, family planning supplies, diabetic supplies, vitamins for children, and prenatal vitamins. Not covered: Drugs for weight gain/loss, cosmetic purposes, hair growth, fertility, less than effective drugs and experimental drugs. Call WVMMIS at 1-888-483-0797 to help you find a pharmacy or to find out if your pharmacy is in network.

Access the WV Medicaid Preferred Drug List (PDL) by visiting: <https://bms.wv.gov/preferred-drug-list-and-coverage-details>. The PDL is subject to regular updates by the WV Medicaid program.

THP covers medicines that you get during a hospital stay and in the emergency room. THP also covers medicine you get in the practitioner's office, such as injectable medicines i.e., vaccines. Drugs, drug products and related services, which are defined by the Bureau for Medical Services' Outpatient Drug Pharmacy Program as a non-covered benefit will not be covered by THP. Hemophilia blood factors and hepatitis C virus related drugs are covered by traditional Medicaid.

Organ Transplant Services

- 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. Corneal and stem cell transplants shall remain THP responsibility.

School-based Services

- Services provided by a physical therapist, speech therapist, occupational therapist, nursing care agency, or audiologist in a school-based setting. Limited to individuals under age twenty-one (21). Service limitations are listed in the fee for service Medicaid policy manual.



Transportation

- WV Medicaid covers non-emergent medical transportation through a third-party vendor (ModivCare). Members may call 1-844-549-8353 to schedule a trip. Routine transport is required to be scheduled at least five (5) business days in advance of the appointment. You may also receive gas mileage reimbursement if you provide self-transport or receive transportation from a friend or family member. ModivCare will provide a mileage reimbursement trip log to return to them with your appointment information.

Opioid Treatment Program

- Services under the SUD 1115 Waiver Comprehensive opioid MAT program including medication, treatment services and laboratory services.



Mountain Health Trust (WV CHIP) Covered Benefits

Medical

- Primary Care/Specialist Office Visits/FQHC/RHC—Includes physician, physician assistant, nurse practitioner and nurse midwife services.
- Physician Services – Certain services may require prior authorization or have service limits. May be delivered through telehealth.
- Laboratory and X-ray Services –Includes lab services related to substance use disorder (SUD) treatment. Services must be ordered by a practitioner and certain procedures have service limits. Genetic testing requires prior authorization.
- Clinics—Includes general clinics, birthing centers, and health department clinics. Vaccinations are included for children.
- Private Duty Nursing—For children ages 0-20. Requires prior authorization, limits apply.
- Vaccinations - Vaccinations are included for children and as approved for adults.

Hospital

- Inpatient– Includes all inpatient services (including 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.
- Outpatient– Includes preventative, diagnostic, therapeutic, all emergency services, and rehabilitative medical services.

Ambulatory Surgical Care

- Includes services and equipment for surgical procedures.

Emergency

- Post-stabilization– Includes care after an emergency health condition is under control. Care provided in a hospital or other setting.
- Emergency Transportation– Includes ambulance and air ambulance. Out-of-state requires prior authorization.

Rehabilitation

- Pulmonary Rehabilitation – Includes procedures to increase strength of respiratory muscle and functions. Must meet plan guidelines. Limited to 3 sessions per week for 12 weeks or 36 sessions per year
- 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.
- 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). Requires prior authorization.
- Physical Therapy. Twenty (20) visits per year for habilitative and rehabilitative services (combined for physical and occupational therapy).
- Occupational Therapy. Twenty (20) visits per year for habilitative and rehabilitative services (combined for physical and occupational therapy).
- Speech Therapy. Habilitative and rehabilitative services including hearing aid evaluations, hearing aids and supplies, batteries, and repairs (for children under age twenty-one (21). Some procedures have service limits or need prior approval.
- Chiropractor Services. Includes radiological exams and corrections to subluxation. Certain procedures have service limits.



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. Select procedures require prior authorization. Consult with your doctor before receiving services.
- 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 0-20) 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. The Health Plan (THP) has certified American Lung Association Freedom from Smoking facilitators to help you quit smoking. Most people already know that smoking is bad for their health. Our program focuses on how to *quit*, not *why*. Freedom From Smoking is designed to help tobacco users get control of and break their addiction. No one method works for all tobacco users. THP's program is 90 days. A facilitator will call you and help you get any prescriptions approved. They will help you build better habits and break current ones. People who finish the program are six times more likely to be tobacco free one year later than those that quit on their own. If you would like to quit give our facilitators a call at 1-888-450-6023.
- 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 medical 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 12-months 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. Sterilizations are not covered for enrollees under age twenty-one (21), for enrollees in institutions, or for those who are mentally incompetent. Services may be accessed by in network or out of network practitioners.
- Maternity Care—Includes prenatal, inpatient hospital stays during delivery, and post-partum care. Home birth is not covered.

Durable Medical Equipment, Orthotics, and Prosthetics

- Devices and medical equipment prescribed by a physician to ameliorate disease, illness, or injury. Certain procedures have services limits or need prior authorization. Customized special equipment considered.
- Requires prior authorization and must meet THP guidelines.
- Limited replacements.
- Other limitations may apply.



Hospice

- 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.

Home Health Care

- 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 to 2nd certification period.

Dental

For children (ages 0-20)

- Must use participating practitioners (see practitioner directory or call Skygen Dental at 1-888-983-4698).
- Orthodontics covered for the entire duration of treatment regardless of loss of eligibility. Requires prior authorization.

For adults (21 and older)

- Must use participating practitioners (see practitioner directory or call Skygen Dental at 1-888-983-4698).
- WVCHIP adult members have access to all age-appropriate services available under the WVCHIP children's benefit.

Vision

For children (ages 0–20)

- Must use participating vision services practitioners. See practitioner 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 diagnosis.
- Repairs.

For adults (21 and older)

- Adults limited to medical treatment only.
- Medical contact lenses for adults and children covered for certain diagnosis.
- One pair of glasses up to 60 calendar days after cataract surgery.



Diabetes Management

- 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.

Hearing

For children (ages 0–20)

- Audiology screening/testing does not require authorization (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 or devices may have service limits or require prior authorization. Augmentation communication devices are limited to children under 21 years of age and require prior approval.

For adults (21 and older)

- Requires prior authorization for functional testing for specific medical conditions.
- Hearing aid evaluations, hearing aid supplies, batteries, and repairs are not covered for members aged 21 and older.

Behavioral Health

- Behavioral Health Rehabilitation/Psychiatric Residential Treatment Facility – Includes services for children (age 20 and under) with mental illness and substance abuse. Limits frequency and amount of services. Certain services require prior authorization.
- Inpatient Psychiatric Services – Includes treatment through an individual plan of care including post-discharge plans for aftercare. Service is expected to improve the condition or prevent regression so the service will no longer be needed.
 - Under age 21 – Includes services at a psychiatric hospital or psychiatric unit of a hospital. Certification required. Pre-admission and continued stay prior authorization is required.
 - Ages 21 to 64 – Includes treatment at an Institution for Mental Diseases (IMD).
- Outpatient – Includes services for individuals with mental illness and substance abuse. Limits frequency and amount of services. Practitioners must be ACT certified. Children's residential treatment is not covered. Certain services require prior authorization.
- Psychological Services – May be delivered using telehealth. 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 Abuse Disorder (SUD) Services – Targeted case management, residential services, peer recovery support services and counseling services to treat those with substance abuse. Prior authorization is required.

Abortion – Includes drugs or devices to prevent implantation of the fertilized ovum and procedures for termination of ectopic pregnancy. Physician certification required. All Federal and State laws regarding this benefit apply.



Benefits Under Fee-for-Service WVCHIP (For more information on fee-for-service benefits, visit: <https://bms.wv.gov>)

Early Intervention Services for Children Three and Under – Includes services and supports provided through the West Virginia Birth to Three program for children under age three (3) who have a delay in their development, or may be at risk of having a delay, and for their families.

Tubal Ligation – Family planning service for individuals of childbearing age to permanently prevent pregnancy. Service requires informed consent and medical necessity.

Personal Care Services – Includes personal hygiene, dressing, feeding, nutrition, environmental support, and health-related functions. Room and board services require physician certification. May not exceed 60 hours per month without prior authorization.

Prescription Drugs – Includes dispensed drugs on an ambulatory basis by a pharmacy, family planning supplies, diabetic supplies, vitamins for children, and prenatal vitamins. Not covered: Drugs for weight gain/loss, cosmetic purposes, hair growth, fertility, less than effective drugs and experimental drugs. Call the WVMMIS HelpDesk at 1-888-483-0797 to help you find a pharmacy or to find out if your pharmacy is in network. *You can also find this information at wvmmis.com.

THP will still cover some drugs. We cover medicines that you get during a hospital stay and in the emergency room. We also cover those you get in the doctor's office, such as injectable medicines like vaccines. Drugs, drug products and related services, which are defined by the Bureau for Medical Services' Outpatient Drug Pharmacy Program as a non-covered benefit will not be covered by THP. Hemophilia blood factors and hepatitis C virus related drugs are covered by WVCHIP FFS

Organ Transplant Services – 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. Corneal and stem cell transplants shall remain THP's responsibility.

Transportation – WVCHIP covers non-emergent medical transportation through a third-party vendor (ModivCare). Members may call 1-844-549-8353 to schedule a trip. Routine transport is required to be scheduled at least 5 business days in advance of your appointment. You may also receive gas mileage reimbursement if you provide self-transport or receive transportation from a friend or family member. ModivCare will provide you with a mileage reimbursement trip log to return to them with your appointment information.

Opioid Treatment Program – Services under the SUD 1115 Waiver Comprehensive opioid MAT program including medication, treatment services and laboratory services.



MHT Benefit Exclusions

Select services are not available through THP or Medicaid/WVCHIP. If a member chooses to get these services, the member may have to pay the entire cost of the service. THP is not responsible for paying for these services and others:

- All non-medically necessary services.
- Services from non-enrolled or non-participating practitioners.
- Services that require prior authorization but did not get a prior authorization.
- Sterilization of a mentally incompetent or institutionalized individual.
- Except in an emergency, inpatient hospital tests that are not ordered by the attending practitioner, acting within the scope of practice, who is responsible for the diagnosis or treatment of a particular member's condition.
- Treatment for infertility and the reversal of sterilization.
- All cosmetic services, except in the case of accidents or birth defects.
- Christian science nurses and sanitariums.

This is not a complete list of the services that are not covered by THP. If a service is not covered, not prior authorized, or is provided by an out-of-network practitioner, the member may be responsible. If you have a question about whether a service is covered, please call THP at 1-888-613-8385.



Additional Resources for Mountain Health Trust Members

Program	Description	MHT Population	Contact Information
Tobacco Cessation	THP'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: • Developing a plan to quit • Getting support and encouragement • Learning new skills and behaviors • Getting medication, if necessary, to assist with quitting and how to take it correctly • Preparing for relapse and difficult situations	All	1.888.613.8385
Non-Emergent Transportation	• Members with Medicaid or WVCHIP may be eligible for transportation services • Members can contact NEMT broker to schedule a reservation	All	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)	All	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)	All	1.304.558.5388
Children with Special Healthcare Needs (CSHCN)	CSHCHN Program was created to assist families who have children with conditions that need special care	All	1.304.558.5388
Teladoc	24/7/365 access to practitioners for non-emergent issues	All	1.800.TELADOC (1.800.835.2362)



Practitioner Hours of Operation

Practitioners must ensure hours of operation for members' care are convenient, do not discriminate against members, and are no less than the hours of operation offered to commercial members or to Medicaid fee for service. Practitioners must ensure that waiting time to be seen is minimal and that the MHT member waiting time standard is the same wait time standard for commercial members. Practitioners cannot discriminate against MHT members in the order that members are seen, or in the order that appointments are given (meaning, practitioners are not permitted to schedule "Medicaid-only" days).

Cultural Competency and Social Determinants of Health (SDoH)

Mountain Health Trust (WV Medicaid and WVCHIP) practitioners are required to perform healthcare services in a culturally competent manner to all members. This includes members with limited English proficiency and/or reading skills, those with diverse cultural and ethnic backgrounds, the homeless, and individuals with physical and mental disabilities, regardless of sex, sexual orientation, or gender identity.

To ensure that practitioners provide services in a culturally competent manner, THP developed cultural competency and social determinants of health (SDoH) practitioner education. THP's Cultural Competency/Social Determinants of Health Training is available on THP's [provider portal](#) Resource Library. THP's Practice Management Consultants (PMC) are available for individualized education sessions. To request a training session, please [contact your PMC](#).

Practice Training Guidelines

Practitioners should develop training program(s) for staff inclusive, but not limited to, member needs that can help with addressing physical, behavioral and environmental health e.g., Adverse Childhood Experiences (ACEs) and Motivational Interviewing.

THP can provide training materials on these topics, upon request.

Information regarding THP's clinical guidelines and policies is available at the following links:

<https://www.healthplan.org/practitioners/resources/policies/medical-policies>

<https://www.healthplan.org/practitioners/resources/policies/payment-policies>

<https://www.healthplan.org/practitioners/prior-authorization-referrals/forms-prior-auth-list-notices>

*Lists are not all-inclusive.



HealthCheck (EPSDT)

Early and periodic screening, diagnosis, and treatment (EPSDT) are medically necessary services, including interperiodic and periodic screenings, listed in section 1905(a) of the Social Security Act. EPSDT entitles MHT-eligible infants, children, and adolescents to any treatment or procedure that fits within any of the categories of MHT-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 practitioner should perform the screening (periodic, comprehensive child health assessments) for all eligible members.

EPSDT services 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 from a PCP to a dentist for children beginning six months after the first tooth erupts or by 12 months of age); The PCP must encourage members to see their dental practitioner at least once every six (6) months for regular check-ups, preventive pediatric dental care, and any services necessary to meet the MEMBER'S diagnostic, preventive, restorative, surgical, and emergency dental needs.
8. Behavioral health screening; and
9. Health education (including anticipatory guidance).

It is important to document all the above on the member's chart or electronic health record (EHR) as well as referrals. The practitioner should submit an 837P or 1500 claim form with the appropriate diagnosis codes, and procedure codes and modifiers. The EP modifier must be appended on all EPSDT service line(s).

EPSDT claims are paid without any coordination of benefits (COB). Further information including current EPSDT forms and periodicity guidelines is available at:

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

If the practitioner performs a well-child exam at the same time as a sick visit, please use the appropriate diagnosis, procedure, and modifier codes.

THP members receive a reminder notice that a well-child exam is due.



Medicaid Copays

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

Service	Tier 1 Up to 50% FPL	Tier 2 50.01 to 100% FPL	Tier 3 100.01% of FPL
Inpatient hospital (acute care 11x)	\$0	\$35	\$75
Office visit (practitioners) (99201-99205, 99212-99215 only for office visits for new and established patients based on level of care)	\$0	\$2	\$4
Non-emergency use of emergency department hospital only (Lowest level, 99282, of emergency room visits in hospitals. The definition of this visit is an emergency department visit for the evaluation and management of a patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision-making)	\$8	\$8	\$8
Any outpatient surgical services rendered in a practitioner office, ASC or outpatient hospital, excluding emergency rooms	\$0	\$2	\$4

Members and practitioners 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:

Tier Level	Out-of-Pocket Maximum
1 (Up to 50% FPL)	\$8
2 (50.01 - 100% FPL)	\$71
3 (100.01% FPL and above)	\$143



Copayment Exemptions

As of January 1, 2014, some individuals who receive Medicaid services will be expected to pay copayments for certain services.

Exempt from the copayment requirements are:

- Behavioral health
- Pregnant women, including pregnancy-related services up to 12-month postpartum
- Children under age 21, and
- Native American and Alaska natives.

Services exempt from copayment include:

- Long term care
- Hospice
- Medicaid waiver
- Breast and Cervical Cancer Treatment Program
- Family planning, and
- Emergency services

Copayments are based on the member's level of income and may not exceed 5% of the member's household income. Practitioners may not deny services to individuals whose income falls below 100% of the federal poverty level due to their inability to make a copayment.

Medicaid 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 DRWVPROD

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.

For prescribers issuing controlled substances, prescribers must review the WV PDMP in accordance with Section 5042 of the SUPPORT Act. In the case that a prescriber is not able to check the PDMP despite a good faith effort by the prescriber, the prescriber must document such good faith effort, including the reason(s) why the prescriber was not able to check the PDMP. Prescribers may be required to submit, upon request, such documentation to Medicaid.



WVCHIP Copays

WVCHIP members participate in some level of cost sharing (copayments and premiums), except for those children registered under the federal exception for Native Americans or Alaskan Natives.

There are no copayments for maternity services or pregnant women 19 years of age or older.

WVCHIP has three enrollment groups in the plan. Each enrollment group has a different level of cost sharing.

Medical Services and Prescription Benefits	WVCHIP Gold	WVCHIP Blue	WVCHIP Premium
Generic Prescriptions	No copay	No copay	No copay
Listed Brand Prescriptions	\$5	\$10	\$15
Multisource Prescriptions	No copay	\$10	\$15
Primary Care Practitioner Medical Home Visit	No copay	No copay	No copay
Practitioner Visit (non-medical home)	\$5	\$15	\$20
Preventive Services	No copay	No copay	No copay
Immunizations	No copay	No copay	No copay
Inpatient Hospital Admissions	No copay	\$25	\$25
Outpatient Surgical Services	No copay	\$25	\$25
Emergency Department (waived if admitted)	No copay	\$35	\$35
Vision Services	No copay	No copay	No copay
Dental Benefit	No copay	No copay	\$25 copay for some non-preventive services

Note: Copayments are waived for all PCP office visits.



Out of Pocket Maximums

The maximum copayment amounts applied during a benefit year are as follows:

# of Children Copay Maximum	WVCHIP Gold	WVCHIP Blue	WVCHIP Premium
1 Child Medical Maximum	\$150	\$150	\$200
1 Child Prescription Maximum	\$100	\$100	\$150
2 Children Medical Maximum	\$300	\$300	\$400
2 Children Prescription Maximum	\$200	\$200	\$250
3 or more Children Medical Maximum	\$450	\$450	\$600
3 or more Children Prescription Maximum	\$300	\$300	\$350
Dental Services	Does not apply	Does not apply	\$150 per family

WVCHIP Prescription Benefit

Pharmacy services for WVCHIP 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 DRWVPROD

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.



Mountain Health Trust Out-of-Network Non-Patient Facing Practitioner Reimbursement and Emergency Reimbursement

Effective August 1, 2019, services rendered by out-of-network non-patient facing practitioners 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 practitioners will be at 80% of the current MHT fee schedule.

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

Under federal law and WV State code, the MHT program prohibits balance billing by all practitioners, regardless of location. Practitioners may not balance bill enrollees for covered services. More specifically, a participating practitioner cannot bill the difference between the practitioner's charge and the allowed amount. Practitioners must be compliant with Section 1902 (n)(3)(B) of the Social Security Act, and Section 1417 of the Balanced Budget Act of 1997. 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 MHT-covered services are eligible for reimbursement. The documentation provided with the claim must clearly indicate an emergency existed.

THP 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 THP.

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.



Family Planning

Family planning services are defined as those services provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy.

Family planning services may be obtained by a Mountain Health Trust member without a referral or prior authorization through any MHT family planning practitioner, regardless that family planning practitioner's THP participation status.

Family planning 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 practitioner
- 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

THP contracts with West Virginia Health Departments to provide certain MHT services 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 practitioner. Environmental lead assessments for THP's pediatric members with elevated blood levels will be reimbursed directly by the State Bureau for Public Health. THP is responsible for reimbursing those blood lead screenings.



Vaccines For Children (VFC) Program

The Vaccines for Children (VFC) program is a federally funded program administered by the State Bureau's Public Health Immunization Program, that helps provide immunizations to WV children younger than 19 years of age and is one of the following: Medicaid-eligible, Uninsured, Under-insured, American Indian, or Alaska Native. Vaccines available through the VFC program are those recommended by the Advisory Committee on Immunization Practices (ACIP) and approved by the Centers for Disease Control and Prevention (CDC).

For more information about the VFC program, visit: <https://www.cdc.gov/vaccines/programs/vfc/index.html>

Surgical Sterilization Consent Forms

THP, in accordance with WV Medicaid / WVCHIP guidelines, will continue to require state surgical consent forms for:

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

The surgical sterilization consent forms for voluntary sterilizations must be completed and signed by the WV Medicaid / WV CHIP member 30 days prior to the surgery. The consent form is valid for 180 days. THP does not need the surgical consent form, but it must be kept with the member's medical records.

Surgical sterilization consent forms are available at healthplan.org.

Effective July 1, 2020, THP will reimburse for tubal ligation regardless of the number of days from the members consent and the tubal ligation.



Pregnancy Billing and Newborn Enrollment and Billing

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, THP adopted the state's pregnancy and newborn guidelines. THP requires all practitioners rendering antepartum care to submit the appropriate code for each encounter during the antepartum period; those antepartum services will be separately reimbursed. THP also requires separate billing for the delivery and postpartum services.

THP requires Prenatal Risk Screening Instrument (PRSI) to be completed upon the initial pregnancy encounter when the estimated confinement date (EDC) date is determined. Practitioners are asked to complete the PRSI and fax the completed form to THP at 740.695.5297.

The PRSI form is available on the West Virginia Department of Human Services' (DoHS) Office of Maternal, Child and Family Health website: dhhr.wv.org "Office of Maternal Child & Family Health" "WV Prenatal Risk Screening Instrument Form."

Based on this screening tool, THP contacts members to begin tracking their pregnancy. THP expects an initial prenatal care visit to be scheduled within fourteen (14) days of when a THP member 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, they are also referred to the tobacco cessation program. Outreach representatives monitor the low-risk pregnancies on a trimester basis. THP will encourage members to participate with the Women, Infant, and Children's (WIC) program.

When THP MHT member gives birth, her newborn(s) is automatically covered from date of birth. THP's enrollment specialist calls new mothers in the hospital to enroll the newborn(s). The new mother is reminded to apply for a Social Security Number for the newborn and to select a PCP for the baby. THP will encourage well-child visits and immunizations and will mail a newborn packet with the newborn's member ID card.

THP's outreach representatives make postnatal contacts to mothers of newborns. This contact is done to remind the member to schedule a postpartum checkup within eight weeks of delivery and to review the Edinburgh Postnatal Depression Scale (EPDS) for postpartum depression. If the member has a high EPDS score, they are referred to THP's prenatal care coordinators who notify the member's OB practitioner.

Members 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, THP 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.

These services are in consultation with the attending practitioner and the member and approved as medically necessary and appropriate by THP.

THP allows women to have direct access to a range of women's health care practitioners, 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

THP encourages members to participate in THP's tobacco cessation classes which are free of charge. A THP staff member will provide the member with one-on-one personal support that can help the member with tobacco cessation. Members can qualify for THP's tobacco cessation incentive by completing THP's sponsored program. Practitioners can refer a member to this program and others on THP corporate website [here](#).

Diabetes

THP covers Insulin pumps in specific medical cases. THP covers diet management and education. THP covers blood glucose monitors for diabetic members when a participating practitioner writes the order, and the monitor is obtained from a participating practitioner. For WV Medicaid, Continuous Glucose Monitors (CGMs) are covered under the fee-for-service pharmacy benefit. For WV CHIP, CGMs should be submitted as a medical claim to THP.

Diabetic members 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. THP sends diabetic members a yearly coupon as a reminder to have the dilated eye exam.



Medicaid Behavioral Health Services

THP provides behavioral health services as outlined in the Bureau for Medical Services (BMS) practitioner manual. BMS' practitioner manual may be accessed on the [WV DHHR website](#).

The following BMS practitioner manual provides detailed information regarding services typically provided by behavioral health practitioners:

- 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

While THP will cover behavioral health services as required by BMS, THP and BMS may have differing prior authorization requirements. Please refer to THP's website for its prior authorization list.

Behavioral Health Services Not Covered:

- Any services that are covered by fee-for-service
- School-based services
- Children's Residential Treatment

If there is a mental health or substance use emergency, please call 911 right away.

WVCHIP Behavioral Health Services

WVCHIP members do not need a referral for behavioral health services. THP's Member Services team can help families, primary care practitioners, or members locate behavioral health practitioners.

THP provides inpatient acute psychiatric care and outpatient behavioral health services to WV CHIP members. This benefit includes acute inpatient psychiatric care, outpatient mental health services, outpatient, and residential treatment for substance use (alcohol and drugs) services and Applied Behavior Analysis. All practitioners must be fully licensed and credentialed by THP before providing services.

Services may require prior authorization. Please visit THP's prior authorization requirement list [here](#).

Behavioral Health Services Not Covered:

- Any services that are covered by fee-for-service
- School-based services
- Children's Residential Treatment

If there is a mental health or substance use emergency, please call 911 right away.

Court Ordered Services

Medically necessary court ordered treatment services are covered by THP. Court ordered services are subject to WVCHIP medical necessity reviews and determination.



Mountain Health Trust Behavioral Health Billing Guidelines

THP requires credentialing of all licensed behavioral health practitioners operating within a practitioner's practice. WV Medicaid and WVCHIP credentialing and billing rules are aligned.

Unlicensed personnel may not bill for behavioral health services within a practitioner's practice except for supervised psychologists officially approved by the WV Board of Examiners of Psychology and for select exceptions related to OBMAT programs that are defined within THP payment and medical policies. A supervised psychologist must appear in the directory of the West Virginia Board of Examiners of Psychologists at psychbd.wv.gov/license-info/license-search.

This guideline does not apply to practitioner's offices within Licensed Behavioral Health Centers (LBHC). Although the billing procedures described below do not apply to FQHC/RHC, the requirement for credentialing does apply to those agencies.

THP, in conformity with Mental Health Parity rules, does not require prior authorization for clinic-based behavioral health outpatient services. THP's prior- authorization list is available on the [corporate website](#) "For Practitioners" section.

For additional information regarding behavioral health billing, please refer to THP's medical and payment guidelines at the following links:

<https://www.healthplan.org/practitioners/resources/policies/medical-policies>

<https://www.healthplan.org/practitioners/resources/policies/payment-policies>



Medicaid Adult Dental

Dental Services: Adults age 21 and over

West Virginia Medicaid members aged 21 and over qualify for \$2,000 in preventive and restorative dental care. Any amount over \$2,000 is the responsibility of the member. Practitioners may only bill members using the Medicaid fee schedule for any services rendered that exceed \$2,000. The \$2,000 is over a two-year period, effective July 1, 2024, and then resets every two (2) years thereafter.

Skygen USA is THP's dental benefit administrator. Practitioners must contract with Skygen USA before providing services to THP members. To contact Skygen USA call 1.888.983.4690 or access their website and Practitioner Manual at skygenusa.com.

In addition to preventive and restorative dental care, THP members have access to emergent procedures to evaluate and treat fractures, reduce pain, or eliminate infection (without financial cap applied). Specifically, fractures of the mandible and maxilla, biopsy, removal of tumors, and emergency extractions.

For a list of codes available under each benefit, view the BMS' Practitioner Manual Chapter 505 (Oral Health Services) section located at dhhr.wv.gov, then "Practitioners", then "Manual."

Prior authorization may be required for specific services and when service limits are exceeded. Please contact Skygen for a complete listing of codes requiring authorization, as well as any documentation requirements.

Dental services in a hospital setting

All procedures provided by a dentist or oral surgeon in a hospital setting require a prior authorization. Refer to the [BMS website](#) for covered oral health services for adults over the age of 21.

Medicaid Children's Dental

THP covers children's dental services (up to age 21). Skygen USA is THP's dental benefit administrator. Practitioners must contract with Skygen USA before providing services to THP members. To contact Skygen USA call 1.888.983.4690 or access their website and Practitioner Manual at skygenusa.com.

Children's (up to age 21) dental services rendered in hospital setting require the dental practitioner to obtain a prior authorization from Skygen USA. Skygen issues prior authorization, the dental practitioner must contact THP at 1.888.613.8385 to obtain the prior authorization for the hospital services. THP prior authorization.

Oral Health Fluoride Varnish Program

Primary care practitioners may receive reimbursement for fluoride varnish application.

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

The West Virginia statewide immunization information system (WVSIS) for all children, adolescents, and adults is a confidential, computerized information system to maintain immunization records. Children often receive immunizations from several practitioners which fragment the immunization record, causing missed doses or over immunization. The benefits of this registry are access to a current immunization record, better member 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 wvimmm.org/wvsiis.

Appeals and Grievances

Complaints and Grievances

- Members, or their representative with written consent, can file a complaint, also called a grievance, at any time.
- If a member is unhappy with something that happened while receiving health care services, the member can file a complaint or grievance. Examples of why a member might file a complaint or grievance include:
 - The member feels he or she was not treated with respect
 - The member is not satisfied with the health care received
 - It took too long to get an appointment
 - The member does not agree with a decision that we made
- To file a complaint or grievance, the member should call THP at 1.888.613.8385 (TTY:711)
- To file a complaint or grievance in writing, the member may fax it to THP at 1.888.450.6025 or mail it to 1110 Main Street, Wheeling, WV 26003
- The member will need to send us a letter that has:
 - Member's Name
 - Member's Mailing address
 - The reason why the member is filing the complaint and what the member wants THP to do
 - When and where the issue took place

The member's doctor or authorized representative can also file a complaint or grievance on his or her behalf.



If filing a written grievance, THP will send the member an acknowledgement letter within five (5) calendar days. Verbal grievances are acknowledged when we take the member's call. The member can file a complaint or grievance at any time after the event about which they are unhappy. THP will conduct a full investigation after THP receives the complaint or grievance. THP will respond within thirty (30) calendar days and no later than ninety (90) days but may ask for extra time to give an answer.

THP will provide translation services, as needed, at no cost.

Member Appeals

If a member believes their benefits were unfairly denied, reduced, delayed, or stopped, the member has the right to file an appeal with THP. The member also has the right to appeal any adverse decision. The member has the right to be represented by anyone he or she chooses, such as an attorney, healthcare practitioner or a family member, with written consent.

- To file an appeal, the member can call THP at 1.888.613.8385.
- To file an appeal in writing, the member can mail it to THP at 1110 Main Street Wheeling, WV 26003.
- The member will need to send us a letter that has:
 - Member's name
 - Practitioner's name
 - The date of service
 - Member's mailing address
 - The reason why THP should change our decision
 - A copy of any information that the member think supports the appeal, such as written comments, additional documents, records or information related to the appeal

If a member calls and gives an appeal over the phone, THP will acknowledge the appeal verbally at the time of receipt and in a letter within five (5) calendar days. Be sure to read the letter carefully and keep it.

The member must file an appeal verbally or in writing within sixty (60) calendar days from the date of the adverse benefit determination or adverse decision by THP.

THP will send the member a letter to let him or her know when THP has received the appeal. The member has the right to give proof, or claims of fact or law, for the appeal either orally, in person, or in writing. The member has the right to see and get copies of documents that have to do with the appeal, records, the benefits, documents explaining how THP made our decision and any other related information to the appeal for free. Information may include medical necessity criteria, and any processes, strategies, or evidence-based standards used in setting coverage limits.

THP will review the member's appeal. None of the people reviewing it will have been involved in the initial decision to not authorize or pay for the health services being appealed. If the appeal involves a medical issue, reviewer will be 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. THP will provide the titles and qualifications of individuals who participate in the appeal decision review.

THP must process and provide notice to the member regarding the appeal within thirty (30) calendar days.



If THP needs more information for the appeal, or if the member wants to provide more information, the member or THP can ask for fourteen (14) more calendar days to finish the appeal. If THP decides to extend the review time to finish the appeal, the member will be notified in writing within two (2) calendar days that he or she has the right to file a grievance if you disagree with the extension.

Fast (Expedited) Appeals

If the member appeal is about our decision to not approve or pay for some or all of his or her health care services, and the member needs an appeal decision fast because he or she has not gotten the health care services, the member can ask for a fast appeal by calling THP at 1.888.613.8385 or by submitting the request in writing within sixty (60) calendar days of the adverse decision. THP will give a decision notice to the member about the fast appeal within 72 hours after THP receives the appeal.

If the member calls and gives the fast appeal over the phone, THP will acknowledge the appeal verbally at the time of receipt and in a letter. Be sure to read the letter carefully and keep it.

If more information is needed to decide the appeal, THP can ask for fourteen (14) more calendar days to finish the appeal. THP will send a letter within two (2) calendar days telling the member why more time is needed. The member may file a grievance if he or she is unhappy with THP's request for more time. The member may also ask for fourteen (14) more days if he or she needs more time to provide information about the appeal.

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

- Member's name
- Practitioner's name
- Date of service
- Member's mailing address
- The reason why THP should change our decision
- A copy of any information that the member thinks support the appeal, such as written comments, additional documents, records or information related to the appeal

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

The Health Plan
1110 Main Street
Wheeling, WV 26003

Phone Number: 1.888.613.8385
Fax Number: 1.888.450.6025

If THP decides the appeal is not a fast appeal, then THP will handle as a normal appeal as described in the section above. The member has the right to file a grievance if they are unhappy with the decision to deny the fast appeal.

The member has the right to give proof, or claims of fact or law, for the appeal either orally, in person or in writing, but the member must provide this information more quickly under a fast appeal process. Upon receipt of the fast appeal request, the member will also have access to copies of all materials at no cost.



State Fair Hearing Process

If a member is not happy with THP's appeal decision, and the appeal is about THP's decision to deny, reduce, change, or terminate payment for health care services, a member can request a State Fair Hearing. A member, or practitioner on behalf of a member with written consent, 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. The member will receive a notice mailed within ten (10) calendar days before any action is taken. The member must request a State Fair Hearing within 120 calendar days from the notice of THP's appeal decision. The member may also request a State Fair Hearing if THP does not meet the timeframe for deciding on the appeal.

Send requests for State Fair Hearing to:

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

The Bureau for Medical Services/WVCHIP' decision will be written to the member within 90 days of the hearing.

Continuation of Benefits During Appeal or State Fair Hearing Process

- THP will continue benefits during the time of a State Fair Hearing when:
- The member or practitioner on a member's behalf 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 practitioner
 - The original period covered by the original authorization has not expired, and
 - The member requests an extension of benefits within ten (10) calendar days of THP determination.
- To request an extension of benefits, call 1.888.613.8385. THP will reimburse for the services in question when the result of the appeal is to overturn the original decision. THP will pay for some or all the services as determined by the final appeal decision. If the result of the appeal is to uphold the original decision to deny, reduce, change, or end payment for services, THP may recoup reimbursement for those services while the appeal was in process, and the member will be responsible for paying for the services.

Grievances and Appeals Records

THP will maintain member grievance and appeals documents, records, and information for ten (10) years.



Mountain Health Trust Members' Rights

THP members have rights around their health care and to receive information according to contract standards. These rights and responsibilities are available at healthplan.org/legal/member-rights-and-responsibilities.

Annually on April 1, THP submits an annual report to the Bureau for Medical Services (BMS) and WVCHIP. This annual report includes a description of THP's services, personnel, and the financial standing. The annual report is available to members by request. To get a copy of the report, members can call THP at 1.888.613.8385. Members can also get a copy of the report from BMS.

Members have the right to:

- Ask for and obtain all included information
- Be told about their rights and responsibilities
- Get information about THP's services, practitioners, and their rights
- Be treated with respect and dignity
- Not be discriminated against by THP
- Access all services that THP must provide
- Choose a practitioner in THP's network
- Take part in decisions about their health care
- Refuse treatment and choose a different practitioner
- Get information on available treatment options or alternative courses of care,
- Get information presented in a manner appropriate to their condition and ability to understand, regardless of cost or benefit coverage
- Have their privacy respected
- Ask for and to get their medical records within 30 days of request
- Ask that their medical records be changed or corrected if needed within 60 days of request
- Be sure their medical records will be kept private
- Recommend changes in policies and procedures, including, but not limited to, member rights and responsibilities.
- 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 experiencing homelessness
- Refer themselves to in-network and out-of-network family planning practitioners
- 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 their parent or a representative make treatment decisions when they 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 their member handbook annually after initial enrollment
- Disenroll from their health plan
- To exercise their rights. Exercising their rights does not adversely affect THP's treatment of the member
- Ask us about THP's quality improvement program and tell THP how they would like to see changes made
- Ask us about THP's utilization review process and tell us how you would like to see changes made
- Know the date they joined THP
- Know that THP only cover health care services that are part of their plan
- Know that THP can make changes to their health plan benefits after THP informs about those changes in writing
- Get news on how practitioners are paid
- Find out how THP decides if new technology or treatment should be part of a benefit
- Ask for oral interpreter and translation services at no cost
- Use interpreters who are not your family members or friends
- Know they will not be held liable if THP insolvent
- Know their practitioner can challenge the denial of service with your permission
- Be provided with informed consent



MHT Member Responsibilities

- Read through and follow the instructions in THP's member handbook
- Work with their PCP to manage and improve your health
- Ask their PCP any questions
- Call their PCP at any time when you need health care
- Give information about your health to THP and your PCP
- Always remember to carry your member ID card
- Only use the emergency room for real emergencies
- Keep their appointments
- If they must cancel an appointment, call their PCP as soon as possible to let him or her know
- Follow their PCPs recommendations about appointments and medicine
- Go back to their PCP or ask for a second opinion if they do not get better
- Call Member Services at 1-888-613-8385 whenever anything is unclear
- Treat health care staff and others with respect
- Tell THP right away if they get a bill they should not have gotten or if they have a complaint
- Tell THP and their Department of Human Services (DoHS) caseworker right away if they had a transplant or if they are told they need a transplant
- Tell THP and DoHS when they change your address, family status or other health care coverage
- Know that THP does not take the place of workers' compensation insurance



Practitioner Reporting Requirements

Reporting of Required Reportable Diseases

State law requires health care practitioner to report certain diseases. 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 reportable diseases, as necessary to protect the public's health, or (2) screening, diagnosis and treatment of case contacts who are THP members. 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 members with THP may be referred 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—member 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

THP must comply with the following Federal reporting and compliance requirements for the services listed below and must submit applicable reports to BMS. (See [BMS 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. Under WV 2020 Senate Bill 716 tubal ligation (or sterilization) may be provided without waiting 30 days after informed consent.
- EPSDT services and reporting must comply with 42 CFR 441 Subpart B – Early and Periodic Screening, Diagnosis, and Treatment.



Practitioner Fee Schedule Changes

In accordance with THP's contract with BMS, THP will update practitioner fee schedules as follows:

Federally Qualified Health Center / Rural Health Center (FQHC/RHC)

Upon BMS notification to THP of any changes to the FQHC/RHC reimbursement rates, THP must update payment rates to FQHC/RHCs to the effective date in the notification by BMS. THP 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, THP must reprocess the claim to reimburse at the new rate. The new payment rate must be loaded into THP's claims payment system within thirty (30) calendar days of notification of the payment rate change.

THP must offer FQHCs and RHCs terms and conditions, including reimbursement, which are at least equal to those offered to other practitioners of comparable services.

Critical Access Hospital (CAH)

Upon BMS notification to THP of any changes to the CAH reimbursement rates, THP must update payment rates to CAH effective from the designated CMS effective date. 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 new payment rate must be loaded into THP's claims payment system within thirty (30) days of notification of the payment rate change.

Other Fee Schedules

THP is required to implement any rate changes adopted by BMS within thirty (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. THP must reprocess any claims paid between the notification date and the system load date to the updated rate.



Practitioner Overpayments

In some situations, BMS reserves the right to collect overpayments. If this were to occur, BMS will directly notify the practitioner. The practitioner's appeal rights in the event of BMS collecting an overpayment directly from the practitioner are outlined in the BMS Policy Manual, chapter 800(B). See **Chapter 3 – Claims** for additional practitioner overpayment information.

Alternative Payment Models (APMs)

THP collaborates with practitioners to develop APMs to best fit for the practitioners and members' needs.

THP's APM include:

- Care coordination payments
- Pay for quality
- Pay for reporting
- Shared savings, upside only

THP will consider other APMs in the future, such as shared savings, upside and downside, or full risk.



Marketing Guidelines

THP may conduct general advertising that does not specifically solicit the MHT population. THP must submit marketing plans to BMS for prior written approval.

Prohibited Marketing Practices

The following prohibitions are applicable to THP, its agents, subcontractors, and practitioners:

1. Distributing Marketing materials without prior BMS approval;
2. Distributing Marketing materials written above the sixth (6th) grade reading level (Grade 6.9 or below), unless approved by BMS;
3. Making any assertion or statement (orally or in writing) that THP is endorsed by CMS, a federal or state government agency, or similar entity;
4. Making any written or oral statements containing material misrepresentations of fact or law relating to THP's plan or the Medicaid and WVCHIP program, services, or benefits;
5. Making false, misleading, or inaccurate statements relating to services or benefits of THP or Medicaid and WVCHIP program, or relating to the practitioners or potential practitioners contracting with THP;
6. Using the word, "Mountain," or phrase, "Mountain Health," except when referring to Mountain Health Trust or other State programs;
7. Marketing in or around public assistance offices, including eligibility offices;
8. Direct Mail Marketing to potential enrollees.
9. Directly or indirectly, engaging in door-to-door, email, text, telephone, and other Cold Call Marketing activities;
10. Using spam (an unwanted, disruptive commercial message posted on a computer network or sent by email);
11. Inducing or accepting an member's THP enrollment or THP disenrollment;
12. Using terms that would influence, mislead, or cause potential enrollees to contact THP, rather than the Enrollment Broker, for enrollment;
13. Using absolute superlatives (e.g., "the best," "highest ranked," "rated number 1") unless they are substantiated with supporting data provided to BMS;
14. Portraying competitors in a negative manner;
15. Referencing the commercial component of THP in any Marketing materials;
16. Knowingly marketing to persons currently enrolled in another MCO directly by mail, phone, or electronic means of communication;
17. Influencing enrollment in conjunction with the sale or offering of any private insurance;
18. Tying enrollment in the Medicaid/WVCHIP MCO with purchasing (or the provision of) other types of private insurance;
19. Charging members for goods or services distributed at THP or Medicaid/WVCHIP events;
20. Charging enrollees a fee for accessing THP's website;



21. Using marketing agents who are paid solely by commission;
22. Purchasing or otherwise acquiring mailing lists from third party vendors, or for paying BMS' contractors or Subcontractors to send plan specific materials to potential members;
23. Assisting with Medicaid/WVCHIP MCO enrollment form;
24. Conducting potential enrollee orientation in common areas of practitioners' offices;
25. Posting THP-specific, non-health related materials or banners in practitioner offices;
26. Allowing practitioners to solicit enrollment or disenrollment in THP or distribute THP-specific materials at a Marketing activity (This does not apply to health fairs where practitioners do immunizations, blood pressure checks, etc. as long as the practitioner is not soliciting enrollment or distributing plan specific THP materials.);
27. Providing gifts to practitioners for the purpose of distributing them directly to the MCO's potential or current members;
28. Offering gifts valued over \$15 or \$75 annually to potential members;
29. Making potential enrollee gifts conditional based on enrollment with THP;
30. Discriminating against an enrollee or potential enrollee because of race, age, color, religion, natural 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 enrollees with certain diagnoses;
31. Failing to provide an opt-out option in SMS/text message materials.

Social Media Marketing Guidelines

THP must comply with the following social media marketing guidelines:

The following list is applicable to THP, its agents, subcontractors, and practitioners:

1. Upon BMS approval, THP may engage in forms of social media advertising (e.g., Facebook, Instagram)
2. Upon BMS approval, THP may purchase advertisement banners on social media outlets. The content of such advertisements must be approved by BMS prior to distribution
3. THP may post Medicaid/WVCHIP events on social media sources. The content of such posts must be approved by BMS approval prior to posting
4. THP may post general non-advertising information regarding THP activities. The content of such posts does not require BMS prior approval, and
5. Any member complaints received through social media sources must be processed and resolved through the general complaint intake system.

Social Media Prohibitions

The following prohibitions are applicable to THP, its agents, subcontractors, and practitioners:

1. Posting or sending personal or protected private health information on social media
2. Advertising on social media platforms that entail direct communication with potential members. 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 members except when to provide a general response, such as giving a phone number or link to a website or the enrollment broker phone number
4. Partaking in individual communication on social media outlets
5. Requesting followers or adding individuals as friends or tagging individuals on social media sources (e.g., Facebook, Instagram, Twitter)
6. Tagging individuals on social media

Reporting and Investigating MCO Marketing Violations

THP's process to ensure fair and consistent investigation of alleged violations of BMS marketing policies is:

Upon written receipt of any alleged violation(s) from BMS, THP 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 MHT Practitioner Required Provisions

THP is contracted with West Virginia Bureau for Medical Services (BMS) and West Virginia Children's Health Insurance Program (CHIP). The West Virginia Mountain Health Trust Program requires specific contractual provisions for all contracted practitioners that participate with the West Virginia Mountain Health Trust program or choose to provide services to West Virginia Medicaid and WVCHIP recipients on an intermittent basis. In addition to the terms contained within the Agreement, the following provisions are applicable specifically to Facility, Practitioner, and Ancillary Medical Care Practitioners that provide services to West Virginia MHT recipients.

A. Obligations of Emergency Care Practitioners

- Emergency Care practitioners must provide education to MHT 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 Practitioners with Respect to Member Copays

- Enrollees will be held harmless for the costs of all MHT-covered services provided except for applicable cost-sharing obligations. Practitioners must inform members of the costs or non-covered services prior to rendering such services.
- Practitioners agree that THP's members may not be held liable for THP's debts in the event of THP's insolvency.
- In accordance with the regulatory requirements promulgated by BMS, practitioners may not routinely waive required copays.
- Practitioners 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.
- Practitioners must charge a copay for the following:
 - Inpatient and Outpatient Services



- Practitioner 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 THP not specifically exempt.

C. Other Obligations of Practitioner

- Practitioner may not refuse to furnish covered services to the eligible member on account of a third party's potential liability for the service(s).
- Practitioner agrees to comply with THP's Quality Assurance/Performance Improvement (QAPI) Program requirements.
- Practitioners that order, refer, or render covered services must enroll with BMS, through the fiscal agent, as a Medicaid/CHIP practitioner, as required by 42 CFR 438.602(b). Enrollment with BMS does not obligate practitioner to offer services under the BMS fee-for-service delivery system. THP is not required to contract with a practitioner enrolled with the West Virginia Bureau for Medical Services/CHIP that does not meet THP's credentialing or other requirements.
- Practitioner must attest to the following certification for claims for MHT 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 member; and
 - The practitioner 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.
- Practitioner shall maintain malpractice insurance with minimum coverage requirements of \$1 million per episode and \$1 million in aggregate.
- Practitioner shall supply a certification that neither practitioner nor practitioner'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 practitioner 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. Practitioner shall notify THP immediately at the time it receives notice that any action is being taken against a practitioner 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. Practitioner 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 Practitioners must comply with timeliness of access standards as defined by BMS.



D. THP's Reimbursement Responsibilities

- THP is solely responsible for payment of covered and authorized services to West Virginia MHT recipients if the member is eligible for services on the date of service. Practitioner shall not seek reimbursement directly from West Virginia Bureau for Medical Services.
- The reimbursement terms for West Virginia MHT recipients are set forth in the Practitioner's Master Agreement.
- THP will not make specific payment, directly or indirectly, to practitioner as an inducement to reduce or limit medically necessary services furnished to any member.
- Members may not be held liable for covered services, for which 1) the State or THP does not pay the individual or health care practitioner that furnished the services under a contractual, referral, or other arrangement; or 2) payments for covered services furnished under a contract, referral, or other arrangement to the extent those payments are in excess of the amount that the enrollee would owe if THP covered the services directly.

E. Reporting Actions against Practitioners, Owners, or Others

- Practitioner must notify THP immediately after it receives notice that any action is being taken against practitioner or any practitioner, 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 practitioner 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

- Practitioner 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. Practitioner 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 members of BMS programs.

G. Compliance with Deficit Reduction Act Requirements

- Practitioner must comply with the Section 6032 of the Deficit Reduction Act of 2005 and the SMDL 06-024. If practitioner receives annual Medicaid payments of at least \$5 million (cumulative, from all sources), the practitioner must:
 - Establish written policies for all employees, managers, officers, contractors, subcontractors, and agents of practitioner. 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).
 - Include as part of such written policies detailed provisions regarding the practitioner's policies and procedures for detecting and preventing Fraud, Waste, and Abuse.



- 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 practitioner's policies and procedures for detecting and preventing Fraud, Waste, and Abuse.

H. Required Disclosures by Practitioner

- Practitioner shall provide THP and BMS with all information requested of practitioner, including required disclosures regarding ownership and control, in accordance with 42 CFR § 455.104. In addition to any other information requested by THP or BMS, practitioner shall disclose the name and address of any person (individual or corporation) with an ownership or control interest in practitioner. 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 Practitioner.

Consistent with 42 CFR § 455.101, THP defines "ownership interest" and "ownership" as follows:

- Ownership interest means the possession of equity in the capital, the stock, or the profits of practitioner.
- 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 practitioner;
 - Has a combination of direct and indirect ownership interests equal to 5 percent or more in practitioner;
 - 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 practitioner practice that is organized as a corporation; or
 - Is a partner in a practitioner practice that is organized as a partnership.
- In addition to the required ownership and control disclosures required by 42 CFR 455.101, practitioner 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 practitioner 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 practitioner's director, officer, principal, partner, agent, managing employee, or other person with ownership or control interest of five percent (5%) or more in the practitioner or in the practitioner'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.



- Practitioner 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 practitioner is related to another person with ownership or control interest in practitioner 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 practitioner has a 5 percent or more interest is related to another person with ownership or control interest in practitioner as a spouse, parent, child, or sibling.
- Practitioner agrees to keep its disclosed information regarding ownership and control current at all times by informing THP, in writing, within thirty-five (35) calendar days of any ownership or control changes.
- Practitioner must disclose any significant business transactions, in accordance with 42 CFR § 455.105. Practitioner 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:
 - The ownership of any subcontractor with whom practitioner has had business transactions totaling more than \$25,000 during the previous 12-month period; and
 - Any significant business transactions between practitioner and any wholly owned supplier, or between practitioner and any subcontractor, during the previous five (5) years.
- Practitioner must disclose any healthcare-related criminal convictions, in accordance with 42 CFR § 455.106, of any practitioner's director, officer, principal, partner, agent, managing employee, or other person with ownership or control interest of five percent (5%) or more in practitioner, relating to Medicare, Medicaid, or Title XX programs. These disclosures are required at the time that practitioner applies or renews its applications for Medicaid participation or at any time on request. Practitioner must notify THP immediately at the time practitioner 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:

 - There is a post-trial motion or an appeal pending, or
 - The judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed;
 - A Federal, State or local court has made a finding of guilt against an individual;
 - A Federal, State or local court has accepted a plea of guilty or *nolo contendere* by an individual or entity; or
 - 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.
- Practitioner shall report to THP all practitioner-preventable conditions associated with claims.



I. Maintenance and Access of Records

- If practitioner places required records in another legal entity's records, such as a hospital, the practitioner shall be responsible for obtaining a copy of these records for use by the government entities or their representative.
- Practitioner must provide to BMS:
 - All information required under THP's managed care contract with BMS, including but not limited to the reporting requirements and other information related to a practitioner's performance of its obligations under its practitioner contract with THP; and
 - Any information in practitioner'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 practitioner places required records in another legal entity's records, such as a hospital, practitioner 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 practitioner shall not use information obtained through the performance of THP 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

- Practitioner is prohibited from engaging in direct marketing to members that is designed to increase enrollment in THP. This prohibition does not constrain Practitioner from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance.

L. Non-Interference with Rights of THP and the State

- Practitioner shall take no actions that interfere with or place any liens upon the State's right or THP's right, acting as the State's agent, to recovery from third-party resources.

M. Compliance with Advance Directives Requirements

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

N. Right to Recover Overpayments from Practitioner

- Practitioner shall notify THP, in writing, of any overpayment discovered by Practitioner. This required notification shall include the reason for any overpayment. Practitioner shall return the full amount of the overpayment to THP within sixty (60) calendar days after the date on which the overpayment was identified.
- BMS has the right to recover practitioner overpayments, including those overpayments due to Fraud, Waste, and Abuse, from practitioner if:
 - BMS or its contractor identifies an overpayment made by THP to practitioner



- The payment occurred outside the grace period, as defined by BMS
 - THP 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 practitioner, and
 - BMS, in its sole discretion, determines it is unable to collect from THP.
- THP may seek recoupment of payments for up to twenty-four (24) months from the date of service of the claim, per its agreement with BMS. For fraud, waste or abuse claims, there is no time limit on recoveries.
 - In the event the State collects overpayments directly from practitioner, practitioner's appeal rights are outlined in the BMS policy manual Chapter 800(B), which can be found on the BMS website.

MHT Drug Testing Policies

THP's policies regarding drug testing are guided by the American Society for Addiction Medicine (ASAM), however, may be more stringent or clearly delineated in some cases. Please consult the ASAM White Paper on drug screening on THP website at www.healthplan.org for further clinical guidelines on use of definitive/definitive drug testing. Please note BMS Chapter 529.2 outlines drug testing availability and limits.

For additional information regarding behavioral health billing for MHT, please refer to THP's clinical and payment guidelines at the following links:

<https://www.healthplan.org/practitioners/resources/policies/payment-policies>
<https://www.healthplan.org/practitioners/resources/policies/medical-policies>

Transplant Services

Members receiving transplant services, with the exception of Corneal and stem cell transplants, are exempt from managed care. Members that have received transplant services or are under evaluation for transplant services shall be disenrolled from THP and placed under fee-for-service coverage for all services.

Inpatient Claims

THP processes claims 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.



Medicaid NDC Rebate Eligible Drugs

THP will not 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 practitioners dispense only rebateable drugs and bill with the NDCs. Now, with the Deficit Reduction Act of 2005, this requirement is being expanded to include practitioner-administered drugs.

Drugs administered by the practitioner and billed with an NDC must be rebateable to be eligible for payment, otherwise the drug will be denied. Practitioners 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 practitioner billing instructions for requirements).

Unit of Measurement codes are:

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

340b practitioners are required to use modifier "UD" when submitting claims.

[FAQs](#) related to this requirement can be found on the BMS website at https://dhhr.wv.gov/bms/BMS%20Pharmacy/Documents/FAQsNDC_HCPCS_012712_v.%208.pdf.



Medicaid Emergency Room (ER) All-Inclusive Reimbursement Rate

THP follows BMS' reimbursement policy for ER all-inclusive reimbursement rates.

The ER all-inclusive reimbursement rate includes

- Use of emergency room
- Routine supplies (e.g., 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 performed during an ER visit 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 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 one (1) unit and \$0.01 charges.

Indian Health Care Practitioners Disclosure

THP follows the requirements related to Indians, Indian Health Care Practitioners, and Indian Managed Care Entities in accordance with the terms of 42 Code of Federal Regulations (CFR) 438.14.

THP permits any Indian who is enrolled in THP and eligible to receive services from a participating Indian Health Service, Tribes and Tribal Organizations, or Urban Indian Health Program (I/T/U) practitioner to choose to receive covered services from that I/T/U provide.



Member Incentives (Value Added Services)

Members may qualify for incentives by completing health activities. By helping members complete these activities, practitioners can help THP reward members who receive needed services.

THP's member incentives include:

Value-Added Services
• Annual well visits: Members up to age 21 - Receive a \$25 gift card. • Maternity: \$100 gift card for six prenatal visits and \$50 for post-partum visit between 7-84 days of delivery. • Diabetes: \$25 gift card for completion of an HbA1c blood test and \$25 gift card for a diabetic eye exam for ages 18-75. • Dental: \$25 gift card for dental exams for children up to age 21. • Mammogram: \$50 gift card for completion of a mammogram, ages 40+. • Cervical Cancer Screening: \$25 gift card for completion of a cervical cancer screening. • Colorectal Screening: \$25 gift card for men and women aged 45-64 for completing an exam. • Boy and Girl Scouts annual membership fee for ages 5-18. • Participation in Member Advisory Committee: Assist THP with better understanding of how to meet your needs • Jobs and Hope West Virginia Assistance: Assist members in referral program. • Teladoc: 24/7/365 access to practitioners for non-emergent treatment. • Meals for Moms: New moms may receive a week's worth of meals following discharge from hospital after newborn delivery. Life Coach: Available to assist with resume development, interview skills and job searches. • Smoking Cessation: \$25 gift card for completing THP smoking cessation course (effective 1/1/2022) • Health Risk Assessment: \$25 gift card for members up to age 21 for completing a Health Risk Assessment These incentives are subject to change January 1 and July 1 each year. Please contact Customer Service to verify most current value adds. Please allow up to six (6) months for members to receive gift card funds due to claim submission process.

Chapter 7

Medicare Advantage (MA)





SecureCare HMO Medicare Advantage Plan

The Health Plan (THP) 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 THP for each Medicare beneficiary who enrolls in a THP plan. This contract requires THP to provide comprehensive health services to persons who are entitled to Medicare benefits and choose to enroll in THP. THP receives a set rate for each member plus any member premium. The benefits for SecureCare Health Maintenance Organization (HMO) members are identical to traditional Medicare benefits along with additional enhanced benefits.

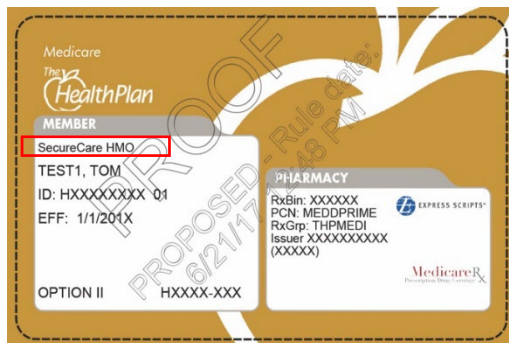
Medicare Advantage benefit plans generally have copays for:

- 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

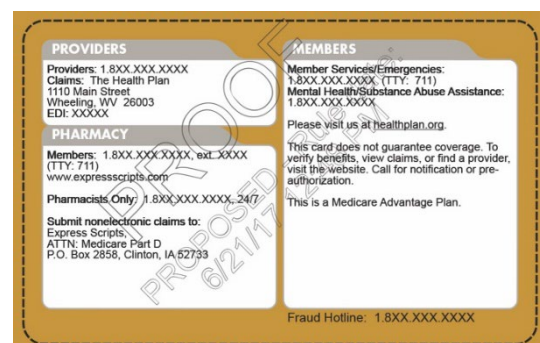
THP Customer Service Department is available to assist with questions and can be reached at 1.877.847.7907.

Sample SecureCare HMO Medicare Advantage Member ID Card

THP Medicare Advantage member ID cards are color-coded orange to more easily identify THP's Medicare Advantage population.



FRONT



BACK



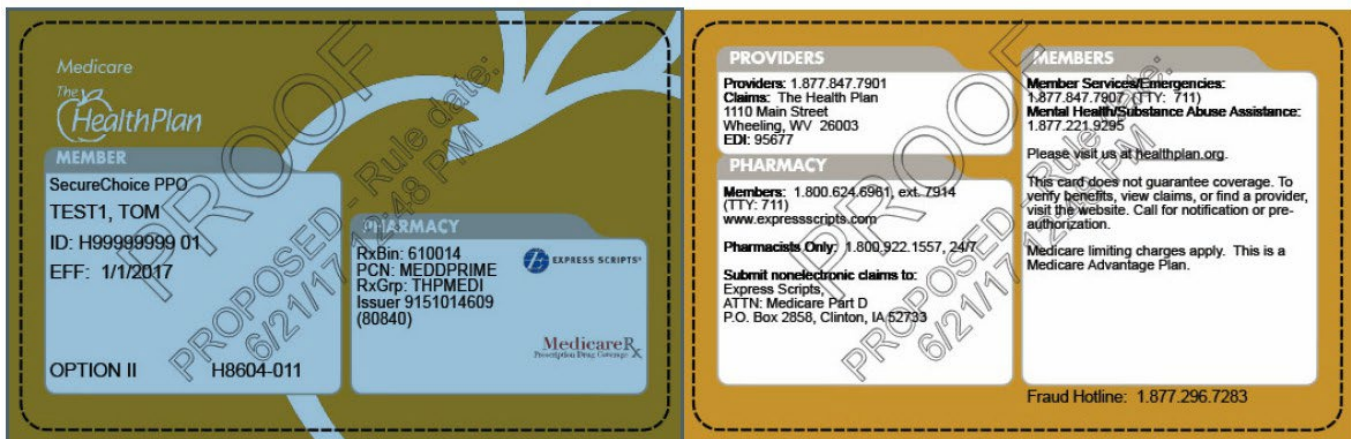
SecureChoice PPO Medicare Advantage Plan

SecureChoice Preferred Practitioner Organization (PPO) is THP's Medicare Advantage preferred practitioner organization (PPO) option. SecureChoice PPO members are not required to select a primary care physician (PCP) and referrals to specialists are not required. THP prior authorization requirements apply.

The SecureChoice PPO plan provides benefits at an "in-network" level from THP's extensive network of participating practitioners. The SecureChoice PPO plan also provides benefits to SecureChoice PPO members at an "out-of-network" level from any Medicare practitioner of choice at an additional out-of-pocket expense to the member.

The benefits for SecureChoice PPO members are identical to traditional Medicare benefits and THP offers enhanced benefits for SecureChoice members. As with the SecureCare HMO plan, it is imperative that you are aware of these rights and responsibilities as a participating practitioner so that you may assist our members within your practice.

Sample SecureChoice PPO Medicare Advantage Member ID Card





Medicare Advantage Dual Eligible Special Needs Plan (D-SNP)

Effective January 1, 2014, THP began a Coordination Only (CO) Medicare Advantage (MA) Dual-Eligible Special Needs Plan (D-SNP) for populations that are dually eligible for both Medicare and Medicaid coverage. D-SNP members are individuals with both Medicare Part A and Part B coverage who also meet the Medicaid eligibility requirements of their state of residence.

Every SNP is required to have a Model of Care (MOC) approved by the National Committee for Quality Assurance (NCQA). The NCQA MOC approval process follows standards and scoring guidelines established by Centers for Medicare and Medicaid Services (CMS). THP received approval as a contracted MA-PD (Medicare Advantage Prescription Drug) plan, which also applies to THP's D-SNP program.

THP's MOC is a written document describing the fundamental framework and measurable goals of the program. THP's MOC implements a comprehensive approach to managing and coordinating care to enhance access to medically necessary care, improve quality of care and ensure continuity of needed services. The care management team uses a Health Risk Assessment Tool (HRAT) designed to assess information collected from the member about their self-perceived health status and develop an individualized plan of care (ICP). As mandated by CMS, THP provides initial and annual MOC training to personnel and practitioners (network and out-of-network) about the program to ensure integrated coordination of care for the D-SNP population.

D-SNP Measurable goals

The following list includes examples of THP's measurable goals for the D-SNP:

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



D-SNP Practitioner Reimbursement and Billing

The practitioner will bill THP for medically appropriate covered services provided to the D-SNP member. THP will reimburse the practitioner for services rendered, according to the member's benefit plan, less any copays, coinsurance, or deductible amounts. The practitioner will then be eligible to submit any balance associated with the copays, co-insurance, and deductible directly to the West Virginia or Ohio Medicaid program. THP accepts full and partial D-SNP members. Members who have partial status may have limited coverage from their state plan.

Changes in reimbursement/fee schedules issued by federal and/or state entities will become effective by THP on the date indicated in the notification.

Federal law prohibits Medicare practitioners 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 practitioners must accept the Medicare payment and Medicaid payment (if any) as payment in full for services rendered to an eligible member. Practitioners who bill a qualified dual-eligible member for amounts above the Medicare and Medicaid payments 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 on the Social Security Administration's website: ssa.gov "Compilation of the Social Security Laws."

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

D-SNP Practitioner education

Each calendar year, all Medicare Advantage participating practitioners must complete and attest to D-SNP MOC training. THP conducts D-SNP practitioner education through several approaches including face-to-face or web-based training and email broadcasts.

THP's D-SNP MOC Annual Training and attestation are located on THP's secure practitioner portal. If training is not complete and attested to each calendar year, THP may issue the practitioner a documented corrective action plan (CAP).

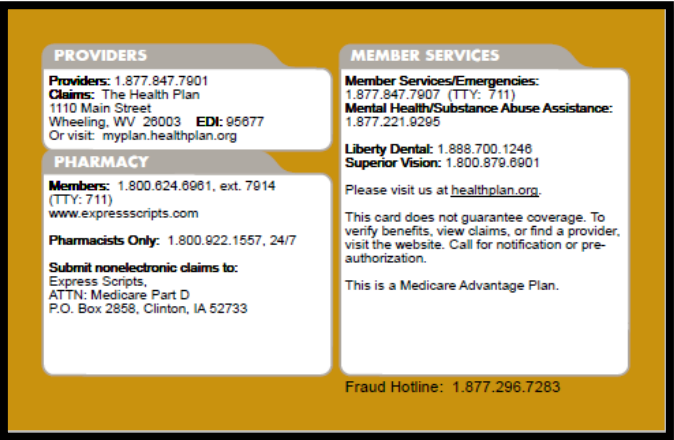
Each CAP will include a sixty (60) day cure period. During the sixty (60) day cure period, THP will:

1. Stop D-SNP member auto-assignment to network practitioners with incomplete D-SNP MOC training.
2. Suspend Alternative Payment Model Category 2 care coordination fees for assigned members, as applicable.

If the CAP is cured, THP will re-start member auto-assignment and re-institute care coordination fees, as applicable. If the CAP is not cured, THP will evaluate network practitioners for removal from the network.



Sample Medicare Advantage Dual Eligible Special Needs (D-SNP) Member ID Card





Vision Service Benefit

Members enrolled through THP Medicare Advantage program have vision benefits. Superior Vision administers routine vision benefits for Medicare Advantage members. Please visit superior vision at superiorvision.com or call 877.235.5317 Monday – Friday 8 a.m. to 9 p.m. EST and Saturday 11 a.m. to 4:30 p.m. EST for information on benefits and coverage under these vision plans.

Practitioners must be credentialed with Superior Vision before offering covered vision services to THP members.

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 THP. A referral from the primary care practitioner (PCP) may be required for the member to obtain medical services from an ophthalmologist or optometrist.

Billing Medical Eye Exams with a Vision Screening

In most situations, a vision screening (CPT 92015 Determination of Refractive State) is considered non-covered and not separately reimbursed as it is a component part of an eye exam.

Billing Procedures

The visit is billed to THP with the following codes:

92002, 92004, 92012, or 92014	Eye exam, new or established patient
92015	Determination of refractive state

Medicare Advantage Coordination of Benefits (COB)

Medicare Advantage is not always the primary payer for health insurance claims. THP 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
- Employer Group coverage based on the Medicare secondary payer guidelines.

THP Insurance Company Medicare Supplemental Plans

Original Medicare beneficiaries who have Original Medicare as their primary insurance can select a THP Medicare Supplement Plan and pay a monthly premium to THP to cover their Medicare deductibles and coinsurance. These plans do not require a member to choose a primary care practitioner (PCP) or obtain a referral for specialty physician services.



Medicare Non-Covered Service Guidelines

THP Medicare Advantage plans, SecureCare (HMO), SecureChoice (PPO), or SecureCare SNP (HMO SNP), fall under Medicare Advantage (Part C) rules. These rules require THP to provide appropriate notice of non-coverage/coverage to the members and educate practitioners 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 practitioners understand the member's role and responsibility regarding covered and non-covered medical services, THP provides this training information as a guide.

Providing Notice of Non-Coverage

The first method THP utilizes to educate members of non-covered services is provided upon enrollment, through the Evidence of Coverage (EOC) booklet Chapter "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 prior authorization, coverage determination, or organization determination) process.

For every service billed to THP, the member receives an Explanation of Benefits (EOB) that provides an explanation of the charges and what, if any, the member is financially responsible for paying to the practitioner.

Unsure if Covered

For a service or item that is typically not covered but could be covered under specific conditions i.e., 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 practitioner acting on behalf of the member, to request a pre-service determination.

Never Covered

If a service is never covered by THP (statutorily excluded from coverage per Medicare rules) and THP's EOC provided to the member is clear that the service or item is never covered, THP 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 THP receives and denies, a standardized denial notice, as stated above, is provided with appeal rights. The member, or treating practitioner, has the right to appeal any denial of a service or item. THP will not take punitive action against practitioners who request an expedited resolution or support a member's appeal.



Member Liability

When the practitioner or THP acting on behalf of the practitioner, 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 THP; or
- b) That coverage is available only if the member is referred for the service by a contracted practitioner 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 practitioner.

Medicare Advantage Billing Rules

This section explains how and when to bill a member for non-covered services.

As a contracted practitioner with THP, you must always submit a claim for payment of services to THP 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

Practitioners should append this modifier when you informed/explained to the member that their THP EOC includes a "clear" exclusion, and the service was not covered.

GA - Pre-service notice of non-coverage was provided by THP

Practitioners should append this modifier when:

- o A pre-service determination was requested and the "Notice of Denial (or partial denial) of Medical Coverage" was issued; or
- o The member either refused your offer of obtaining a pre-service determination or wanted to proceed with the service

Note: When using the GA modifier please provide the pre-service determination number on the claim

When practitioners bill with these modifiers, the claims are processed with the appropriate codes for member financial liability, and you may bill the member. If you bill for non-covered services without using the GA or GY modifier, THP will deny your claim as practitioner responsibility. If you bill THP for covered services with the GY or GA modifier, THP will deny the claim for incorrect use of modifier. Part of your responsibility as a participating practitioner is to inform your members when a service is not covered (or statutorily excluded) by THP.



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 practitioners 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 CMS’ Claims Processing Manual Chapter 1 and MLN Booklet available on CMS’ website [cms.gov](https://www.cms.gov).

Quality Measures and Standards

CMS implements quality initiatives to ensure 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. Please visit **Chapter 11 - Quality** for additional information.

Quality measures are tools that help measure or quantify healthcare processes, outcomes, member 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, member-centered, equitable, and timely care.



Member Incentives

THP encourages its members to participate in preventive care screenings. Medicare Advantage HMO and PPO members may qualify for incentives by completing select health activities. Eligible members will receive their reward to their InComm Card after THP receives the claim for services rendered.

THP's member incentives include:

- Medicare Annual Wellness Visits - \$25
 - Eligible screening codes for Medicare Annual Wellness Visit:
 - G0402 – Initial Preventive Physical Exam
 - G0438 – Initial Annual Wellness Visit
 - G0439 – Subsequent Annual Wellness Visit
 - G0468 – Federally Qualified Health Center (FQHC) Annual Wellness Visit

For additional information on Annual Wellness Visits and requirements, visit

<https://www.cms.gov/medicare/coverage/preventive-services/medicare-wellness-visits>.

- Colorectal Cancer Screening - \$25
- Breast Cancer Screening - \$25



Appointment of Representative Statement for a Medicare Member

To appoint a representative, a Medicare member should complete the form entitled: Appointment of Representative -CMS-1696 – PDF at [https://www.cms.gov/medicare/cms-forms/cms-forms-items/cms012207](https://www.cms.gov/medicare/cms-forms/cms-forms/cms-forms-items/cms012207). Appointment of Representative Forms are available in English, Spanish, and Large Print.

If the member does not use form CMS-1696, the member's appointment must:

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

Unless revoked, an appointment is considered valid for one (1) 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 if 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.



Notice of Medicare Non-Coverage (NOMNC)

When to Deliver the NOMNC

A Medicare practitioner, or THP, must deliver a completed copy of the Notice of Medicare Non-Coverage (NOMNC) to members (or the beneficiary's appointed or authorized representative) for members 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 (2) calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily.

Practitioner Delivery of the NOMNC

Practitioners must deliver the NOMNC to all members eligible for the expedited determination process per section §260 of Chapter 30 of the Medicare Claim Processing Manual (<https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c30.pdf>) or Section 100.2 in the Part C & D Enrollee Grievances, Organization/Coverage Determination, and Appeals Guidance Section of the [Medicare Managed Care Manual](https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Parts-C-and-D-Enrollee-Grievances-Organization-Coverage-Determinations-and-Appeals-Guidance.pdf) (<https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Parts-C-and-D-Enrollee-Grievances-Organization-Coverage-Determinations-and-Appeals-Guidance.pdf>.)

A NOMNC must be delivered even if the member agrees with the termination of services. Medicare practitioners are responsible for the delivery of the NOMNC. Practitioners may formally delegate the delivery of the notices to a designated agent such as a courier service; however, all requirements of valid notice delivery apply to designated agents.

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

Instructions and CMS Forms are available on the CMS website at <https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Notices-and-Forms>



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 hospitals and critical access hospitals (CAHs) to provide written and oral notification to Medicare members receiving observation services as outpatients for more than twenty-four (24) hours. The written notice must include the reason the member 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 CMS to serve as the standardized written notice. Effective March 8, 2017, the MOON must be presented to Medicare members, 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 member or a person acting on behalf of the member ("representative") to acknowledge receipt of the notification. If the member 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 at <https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Notices-and-Forms>

THP monitors hospitals and critical care hospitals annually for MOON compliance.



Medicare Appeals Overview

When a member requests coverage for a particular service, the decision on whether to provide such coverage is considered an "Organization Determination." Members have the right within 65 days of a denial to request either a standard pre-service (30-day), a post service claim (60-day) or an expedited (72 hours) reconsideration whenever THP denied a member's request for services. Part B drugs will have a standard turn-around time of seven (7) days effective January 1, 2020.

Where THP affirms its advice "Organization Determination" in whole or in part, THP 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 member (including their representative)
- An assignee of the member (i.e., a practitioner who has furnished a service to the member and formally agrees to waive any right to payment from the member for that service)
- The legal representative of a deceased member's estate; or
- Any other practitioner or entity (other than the Medicare health plan) determined to have an appealable interest in the proceeding.

Who may request reconsideration (Parts C&D Enrollee Grievances, Organization/Coverage Determination, and Appeals Guidance – 50.1):

1. A member, a member's representative or a non-participating practitioner to THP may request that the determination be reconsidered; however, participating practitioners do not have appeal rights. A member, a member's representative, or practitioner (regardless of whether the practitioner is affiliated with THP) are the only parties who may request that THP expedite a reconsideration.

For standard pre-service reconsiderations, a practitioner who is providing treatment to a member may, upon providing notice to the member, request a standard reconsideration on the member's behalf without submitting a representative form.

If the reconsideration request comes from the member's primary care practitioner in THP's network, no member notice verification is required.

If the request comes from either a participating or non-participating practitioner, and the member's record indicates they visited this practitioner at least once before, THP may assume the practitioner has informed the member about the request and no further verification is needed.

If this appears to be the first contact between the practitioner requesting the reconsideration and the member, THP is to undertake reasonable efforts to confirm the practitioner has given the member appropriate notice. For example:

- If the practitioner makes the request by phone, during the call, a health plan may confirm the practitioner gave the member notice that they are acting on the member's behalf.
- The practitioner makes the request by a fax, letter, or email, and copies the member on the correspondence, and/or the writing includes a statement affirming that the member knows that the physician is acting on the member's behalf with the member's knowledge and approval.



- THP may call the member and ask if they know the practitioner making the request is acting on their behalf with their knowledge and approval.

An Important Message from CMS about Member's 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 members) 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 instructions can be found on the [CMS website](https://www.cms.gov) at CMS.gov.

Detailed Notice of Discharge (Form CMS 10066)

A member who wishes to appeal the determination made by the facility or THP 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 THP or the admission did not constitute emergency or urgently needed care and the PRO upholds THP'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 THP through the appeal process.

Request forms and instructions can be found on the [CMS website](https://www.cms.gov) at CMS.gov.

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 practitioners 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.

The member should make the practitioner aware of their QMB status by showing both their Medicare and Medicaid or QMB card each time they receive care. A member should not get a bill for covered medical services.



Medicare Practitioner Rights and Responsibilities

Overview of Practitioner Responsibilities

Primary Care Practitioners (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 Practitioners Must

- Arrange for the provision of medical services to THP'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 THP.
- 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 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 THP, 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 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 practitioner'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 THP medical records policy, quality assurance programs, medical management programs, and HEDIS® data collection.



CMS Marketing Guidelines:

- Comply with [CMS Marketing Guidelines](https://www.cms.gov/Medicare/HealthPlans/ManagedCareMarketing/FinalPartCMarketingGuidelines) (available online at <https://www.cms.gov/Medicare/HealthPlans/ManagedCareMarketing/FinalPartCMarketingGuidelines>) for practitioner-based activities. The guidelines govern how practitioners can and cannot inform or educate members about enrollment and plan information.

SecureCare/SecureChoice Member 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 receive information from us in a way that works for you, please call Customer 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 THP 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.

Visit healthplan.org to access the full Member Rights and Responsibilities.

Chapter 8

Behavioral Health





Introduction

THP's nurse navigators (case managers) blend behavioral components such as motivational interviewing with disease management and other aspects of medical and behavioral health case management to address THP member needs. The care manager may link the member to primary care, specialty care, and behavioral health practitioners and address social determinants of health (SDoH).

Refer to **Chapter 9 - Clinical** for information about integrated care for THP members. THP's 24-hour phone number is 1.866.NURSEHP (1.866.687.7347) for any THP member needs. This number is answered by nurse navigators who can assist practitioners and members.

Behavioral health admissions may be reported through THP's secure provider portal at myplan.healthplan.org.

Review Criteria

Nationally recognized clinical criteria are utilized to perform reviews for medical appropriateness, allowing for consideration of the needs of the individual member's circumstances, medical history, and availability of care and services within THP network. Input is sought annually, or as needed, in the review of criteria from practitioners in the community and those who serve as members of the Physician Advisory Committee (PAC). When specific clinical expertise is needed to perform a review, or an appeal is presented, reviews are sent to a contracted Utilization Review Accreditation Commission (URAC) or National Committee for Quality Assurance (NCQA) accredited vendor for specialty medical review services by board-certified practitioner reviewers with the same or similar background.

InterQual® Criteria

THP utilizes InterQual® criteria as a screening guideline to assist reviewers in determining the medical appropriateness of health care services. Any participating practitioner, upon request, may review the specific criteria used in an active clinical review process of a procedure requiring the use of InterQual®.

THP uses InterQual® guidelines for most services except for Mountain Health Trust (MHT) groups for whom West Virginia Bureau of Medical Services (WV BMS) has mandated use of other criteria for specific services.

ASAM Criteria

THP utilizes nationally recognized criteria, American Society of Addiction Medicine (ASAM) for a comprehensive set of guidelines, continued stay and transfer/discharge of patient with addiction and co-occurring conditions.

Practitioners should indicate if the request is emergent for expedited review. Scheduling the service does not warrant an expedited review. Unless it is an emergency, scheduling should be done after being approved by THP.



Behavioral Health Prior Authorization

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

The Behavioral Health Prior Authorization Requirements are available on THP's [corporate website](#) and [secure provider portal](#).

THP 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 Commercial Fully Insured, PEIA, Medicare Advantage, or Mountain Health Trust (WV Medicaid and CHIP). However, prior authorization may be necessary for these and other services for Self-Funded groups based on individual plan documents.

Inpatient Treatment, Detoxification, Rehabilitation of Substance Use Disorders and Observation Review

All inpatient services require admission, concurrent, and discharge review by THP. Elective admissions require prior authorization. Admissions to residential facilities for substance use disorders (SUD) must meet ASAM criteria for the selected level of care and require authorization. Intensive Outpatient Programs (IOP) and Partial Hospitalization Programs (PHP) are outpatient services that provide a less intensive level of care, and THP will not require prior authorization for the first thirty (30) sessions for participating practitioners.

If information attached to the prior authorization does not meet review criteria for admission and or concurrent stay, THP's nurse navigator will forward the clinical information for medical director review. The medical director will utilize nationally recognized criteria to provide a clinical review of the case and provide a medical appropriateness determination. If there is an adverse decision, the practitioner can request reconsideration and further review. THP member or their designated representative may appeal as per policy for the line of business.

A peer-to-peer discussion with THP medical directors may be requested by the practitioner.

Intensive Outpatient Services (IOP)

Intensive outpatient services are an intermediate level of care in which individuals are typically seen as a group at least three (3) times per week, three (3) hours per day. Depending on the program's structure, THP will not require prior authorization for the first thirty (30) sessions for participating practitioners. Practitioners should be aware of the following:

- Additional IOP services beyond the thirty (30) sessions can be requested. If the sessions meet criteria for continued programming, the nurse navigator or referral coordinator will continue to allow the course of treatment and inform the practitioner of the number of additional sessions approved. This will continue until discharge.



- Discharge clinical summaries should be submitted to THP for continuity of care.
- If the reviews do not meet criteria, the information submitted by the practitioner will be sent for medical director review prior to denial of services.
- IOP services for non-participating practitioners will be reviewed for medical necessity upon admission. Medical necessity will continue to be reviewed through discharge.
- Practitioners providing IOP to MHT members must be certified by BMS
- IOP services are reviewed in thirty (30) day increments following the initial thirty (30) sessions.

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 from traditional inpatient care for members with moderate to severe symptoms. Treatment is an individualized, coordinated, comprehensive, multidisciplinary program. THP members participate in this structured program up to five (5) days per week, four (4) to five (5) hours per day. Medication management is an integral aspect of partial hospitalization services. THP will not require authorization for the first thirty (30) sessions for participating practitioners.

Practitioners should be aware that:

- Additional Partial Hospitalization services beyond the initial 30 sessions can be requested by submitting a prior authorization request. If the sessions meet criteria for continued programming, the nurse navigator or the referral coordinator 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 summaries should be submitted for continuity of care.
- If the reviews do not meet criteria, the information submitted by the practitioner will be sent for medical director review to determine medical necessity.
- Partial Hospitalization services for practitioners not in network will be reviewed for medical necessity upon admission. Medical necessity will continue to be reviewed through discharge.
- Practitioners providing partial hospitalization to MHT members must be certified by BMS.

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 crises with all care coordinated by the practitioner. Inpatient hospitalization is usually a short-term stabilization and treatment of an acute episode of behavioral health problems. Discharge planning for continued treatment is an integral part of acute psychiatric care.

Prior authorization for 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 PCP, referring participating specialist practitioner or admitting practitioner.



Authorization notification for urgent or emergent admissions by the admitting facility is required at the time of admission. Clinical information is required within 48 hours of admission. This process is in place to generate early discussion of the member's needs as related to the admission, identify alternative health care services, and initiate discharge planning. THP has a process in place for post stabilization care to ensure continuity of care for members requiring post stabilization for medical and behavioral health care services. THP will assist with members needing care by non-participating practitioners when participating practitioners are not temporarily available or accessible.

All inpatient acute psychiatric and detox services require prior authorization.

Concurrent review processes are designed to provide oversight of member progress, ensure delivery of quality care, and promote effective discharge planning. At admission, members are referred by the behavioral health inpatient nurse navigator to the behavioral health transition of care manager (BH TOCM) assigned to that facility. The BH TOCM's primary goal is to facilitate communication, either face-to-face or telephonically, and work collaboratively with members and practitioners to assure successful delivery of behavioral health transition of care services and promote continuity of care and discharge planning.

Inpatient Rehabilitation Facilities

THP reimburses treatment in inpatient rehabilitation facilities such as substance use disorder (SUD) treatment programs, Psychiatric Rehabilitation Treatment Facilities (PTRF) for individuals under age 21, adult psychiatric rehabilitation facilities and short-term residential eating disorder programs, depending on the terms of a specific benefit plan. Treatment must meet medical necessity criteria and must be authorized. The program must be approved by BMS for MHT members.

Outpatient Prior Authorization and Referral Management

Members are afforded direct access to outpatient behavioral health practitioners. Prior authorization may be required for crisis visits or urgent or emergent services. Prior authorization is no longer required for psychotherapy visits or psychological testing depending on the specific benefit plan.

Non-participating and tertiary requests require prior authorization. Clinical information is reviewed for availability of service in network, urgency/emergency of the situation, or other extenuating circumstances. This information should be supplied by the behavioral health practitioner, PCP, or appropriate participating specialist practitioner.

Additional services that require prior authorization include procedure(s) that may have limited coverage under the benefit plan. Experimental and Investigational procedures that have specific coverage guidelines should be prior authorized to assure medical appropriateness and compliance with established standard of care guidelines.

Prior authorizations that do not meet medical appropriateness review by the nurse navigator or referral coordinator is referred to a medical director for review. The medical director may contact the behavioral health practitioner for case discussion. Availability of services within the practitioner network and alternative levels of care for services may be offered as appropriate to the member's needs.

THP reserves the right to conduct clinical and utilization management reviews retroactively on a random or targeted basis to ensure medical necessity and the quality and appropriateness of the service provided.



Drug Screening and Testing

Urine drug testing is most effective when individualized, randomized, and conducted in conformance with principles of assessment recommended by the American Society for Addiction Medicine (ASAM) located on the [ASAM website](#).

ASAM recommends against routine use of definitive testing. Practitioners should review the consensus documentation available at the link above. Clinical procedures may be subject to post payment review for medical necessity.

Behavioral Health Billing

THP requires credentialing of all independently licensed and/or certified behavioral health practitioners within a practitioner practice. Unlicensed personnel may not bill for services within a practitioner's practice except for supervised psychologists officially approved by the WV Board of Examiners of Psychology.

THP follows CMS policy as interpreted for Medicare Advantage and THP Commercial plans unless the Commercial plan description specifies otherwise. Please refer to **Chapter 6 – Mountain Health Trust** for additional information on unlicensed staff billing MHT members.

Medicare Advantage and Commercial Fully Insured Plans

If a licensed behavioral health practitioner is employed or contracted by a practitioner whose scope of practice includes behavioral health, the licensed behavioral health practitioner may bill using the practitioner'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 practitioner's NPI if the scope of the service provided is consistent with the counselor's certification.

If a practitioner is a Medication Assisted Treatment practitioner, regardless of the practitioner's specialty, the practitioner may have behavioral health practitioners employed or contracted in his office billing incident to the practitioner's services only so long as the service being provided relates to the practitioner's prescribing of Medications for Opioid Use Disorder (MOUD) if the practitioner's specialization is not traditionally behavioral health i.e., 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 practitioner 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 practitioner must provide regular reviews of the patient's status which must be documented in the medical record.

If the licensed behavioral health practitioner is listed on the claim as the rendering practitioner, the claim will reimburse 85% of the established Medicare rate. All services provided "incident to" must be provided at place of service 11 (office), or 02 or 10 (telehealth).



Continuity and Coordination of Care

THP Clinical Services Department advocates continuity and collaboration of care between behavioral health and medical practitioners. Continuity and coordination are 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 practitioners whenever clinically appropriate.

It is the responsibility of the behavioral health practitioner to communicate with the PCP and the PCP to communicate with the behavioral health practitioner. Information shared between practitioners should be maintained in the member's medical record. If assistance is required to facilitate this exchange of information to ensure care coordination, THP's Clinical Services Department is available to provide this service.

All federal and state confidentiality laws should be followed. THP expects that information be shared accordingly and recognizes the right to keep progress notes private. THP also understands that there are special situations where information cannot be shared.

Behavioral Health Services Forms

The following forms are provided to assist practitioners in requesting services for members and providing information necessary for continuity and coordination of care. The forms listed below are available online at myplan.healthplan.org.

- Admission Review Form
- Concurrent or Discharge Review Information Form
- Continuity of Care Consultation Form
- Psychological Testing Prior Authorization Request Form
- Treatment Continuation Request Form
- Substance Use Disorder Clinical Review Information Form (for non-MHT)
- Substance Use Disorder Clinical Review Form for MHT Members
- Prior authorization of Drug Screening (labs)
- Request for ACT Programming – MHT Line of Business only
- Peer Recovery Support Services authorization request (MHT Line of Business only)
- Request for ECT
- IOP/PHP Request for Authorization



Telehealth Services

Telehealth services must be conducted using an interactive audio and/or video telecommunications system that permits real-time communications between the practitioner 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 CMS and BMS standards.

Behavioral health Services eligible for telehealth include, but are not limited to: psychotherapy, pharmacological management, diagnostic interview, and neurobehavioral status exam.

Practitioners 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.

Medical record documentation must include the location of the practitioner and the member, an identification of the service as telehealth in nature, and a description of the methodology (audio/visual, audio only, etc.).

- THP follows CMS telehealth service criteria at <https://www.cms.gov/files/document/mln901705-telehealth-services.pdf> for Commercial Fully Insured, Medicare Advantage, and PEIA.
- Mountain Health Trust follows BMS policies at https://dhhr.wv.gov/bms/Provider/Documents/Manuals/Chapter%20519%20Practitioner%20Services/Policy_519.17_Telehealth1.1.22.pdf
- Self-Funded/ASO follows plan documents.

Follow-Up Care after Behavioral Health Admissions

It is 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 an outpatient behavioral health practitioner within seven (7) days of discharge.

Practitioners should:

- Communicate to the hospital discharge planners that follow-up appointments should be scheduled within seven (7) days of discharge.
- Upload discharge documentation on the secure provider portal

Chapter 9

Clinical





Introduction

The Health Plan's (THP)'s clinical services program ensures the provision of appropriate health care 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 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 clinical services program is to measurably improve the utilization of care and services to 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
- 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 and engage for health and wellness/preventive care and clinical programs
- Assess clinical services 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
- Educate practitioners on the scope of the clinical services programs and Clinical Services Division



Prior Authorization Criteria

Nationally recognized clinical criteria are utilized to perform reviews for medical appropriateness allowing consideration of the needs of the individual member, their circumstances, medical history, and availability of care and services within THP network. Input is sought annually, or as needed, in the review of criteria from practitioners in the community and those who serve as members of the Physician Advisory Committee (PAC). In cases where specific clinical expertise is needed to perform a review, or an appeal is presented, reviews are sent to a contracted Utilization Review Accreditation Commission (URAC) or National Committee for Quality Assurance (NCQA) accredited vendor for specialty medical review services by board-certified practitioner reviewers with the same or similar background.

Medical Prior Authorization & Notification Requirements

Practitioners 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, practitioners are required to request prior 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.

To comply with West Virginia prior authorization regulations (Senate Bill 267) practitioners requesting prior authorizations for MHT, WV Commercial, and WV PEIA members are required to submit prior authorizations through THP's secure provider portal.

Effective July 1, 2024, fax and phone prior authorization requests will not be accepted from practitioners.

To register for THP's provider portal, please visit myplan.healthplan.org.

Effective January 1, 2024, THP will follow these Prior Authorization (PA) Response Timelines from receipt of PA, if complete information received:

Line of Business	Standard PA	Urgent PA
Mountain Health Trust (WV Medicaid and CHIP)	5 business days	2 business days
Commercial	5 business days	2 business days
PEIA	5 business days	2 business days
Medicare Advantage	7 calendar days	3 calendar days
Self-Funded/ASO	15 calendar days	3 calendar days



If a PA request is incomplete:

- THP will notify practitioner of the deficiencies within 2 business days of receipt
- Practitioner will have three (3) business days to respond with complete information
- If practitioner responds within three (3) business days with complete information, THP will have two (2) business days from receipt of complete information to render decision
- If practitioner does not respond within three (3) business days, the PA is denied, and a new PA request must be submitted

If a peer review is requested, THP must complete peer review process and render decision within five (5) business days of the request.

If an official PA appeal is submitted, THP must render an appeal decision within ten (10) business days from appeal submission.

The Medical Prior Authorization Requirements are available on THP's corporate website and secure provider portal.

If services are required in less than 48 hours due to medically urgent conditions, please submit an urgent prior authorization. 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.

Services performed without prior authorization will be denied and are not subject to member responsibility. you may not seek reimbursement from members.

eviCore healthcare

THP partners with eviCore healthcare to manage medical necessity and prior authorization for the following services for MHT, Medicare Advantage and Commercial Fully Insured product lines.

- Sleep Studies
- 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)
- Musculoskeletal Conditions
- Spine Pain Management
- Chiropractic care – the first 20 visits do not require prior authorization
- PT and OT – the first 20 combined visits do not require prior authorization



Nurse Information Line

A nurse navigator is available 24 hours a day, 7 days a week to assist with medical management questions but does not provide prior authorizations after normal business hours.

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 practitioner (PCP) or referring participating specialists. This includes acute care, rehabilitation, skilled nursing facilities, and long-term acute care facility (LTACF).

Notification of urgent or emergent admissions by the admitting practitioner or facility, is required at the time of 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.

Non-participating and tertiary non-emergent requests require prior authorization. Clinical information is reviewed for availability of service within the plan 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 Clinical Services inpatient nurse navigator to the Medical Transition of Care Team to evaluate care needs.

Concurrent review involves communication with practitioner(s), hospital utilization review staff, social workers, and family members, as necessary.

Upon discharge from an acute care stay, members receive a follow discharge call and assessment to identify discharge planning needs. If members are identified and opt-in to a program, a referral is sent to care coordination or the Medical Transition of Care team for transitional care needs depending on risk stratification.

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 service does not warrant an expedited review. Unless it is an emergency, scheduling should be done after being approved by THP.



Medical Transition of Care Team

THP implemented a medical transition of care unit to aid in keeping members healthy and out of the hospital. Highly driven by Utilization Management, this program focuses on early identification of members that are high risk for admissions or readmissions by using an iPro admission risk score.

Members can be referred to this program by THP staff. The goal of this program is to keep members healthy and out of the hospital while also assisting with other transition of care needs including but not limited to exhaustion of benefits, finding participating practitioners or transitioning from one plan to another. Once enrolled in the program, the member is periodically contacted for 90 days to ensure all transitional needs are met. If long term needs are identified, the member is referred to care coordination or complex case management dependent on risk stratification.

InterQual® Review

THP utilizes InterQual® criteria as a screening guideline to assist reviewers in determining medical appropriateness for health care services. Any participating practitioner, upon request, may review the specific criteria used in an active clinical review process of a procedure requiring the use of InterQual®. THP uses InterQual® guidelines for most procedures and services other than for MHT where BMS has mandated the use of other criteria for specific services.

PCPs are responsible for directing care to specialty care practitioners. THP does not require a referral to an in-plan specialist in most instances.

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 prior authorization.

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, 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 rendering practitioner should send the report to the referring practitioner who will discuss findings with the member.



Specialist Coordination of Health Care Services

THP facilitates ongoing specialist care and coordination of benefits for members with special health care needs. This would apply when the PCP, in consultation with a specialist practitioner, identifies the need for specialty care for a condition that is life-threatening, degenerative, or disabling.

Specialist Referrals

The PCP is responsible for initiating a specialist referral if one is required by plan design and supplying appropriate member history to the specialist. A treatment plan is formulated by the PCP, specialist, and member. The treatment plan is reviewed by THP's Clinical Services Department.

Standing Referral

Ongoing care over an extended period is requested on a standing referral. Standing referrals are used to prior authorize episodes of specialty care, support tertiary care requirements, or for approved single case agreement (SCA) practitioner referrals. The number of visits shall be based upon the treatment plan and shall be limited to a one-year period. Case management is highly recommended for members requiring standing referrals.

Specialist Acting as Primary Care Practitioner

THP members have the right to select and change their PCP. If the member would like to request a specialist as their PCP, due to a disabling condition, the specialist practitioner must give their signed consent that they will take over the PCP responsibilities for the member.

THP has a review and approval process that must be completed before a specialist practitioner can be listed as a member's PCP. THP will require a "Request Form: Specialist as Primary Care Practitioner" to be completed by the member, current PCP, and specialist practitioner. The form includes information regarding the member's demographic information, current PCP information, reason for requesting a specialist as a PCP, and the information pertinent to the specialist practitioner. After confirmation of qualification through a diagnosed disabling condition, chronic illness, or SSI eligibility, reasons given for requesting a specialist practitioner as a PCP are as follows:

- The specialist is already serving as the member's PCP
- The specialist was recommended by the member's current PCP
- The specialist was requested to serve as the member's PCP

The specialist practitioner will need to supply their name, specialty, NPI, taxonomy(ies) code, practitioner practice name, practitioner office information, and the member's care history with the specialist practitioner. The practitioner will need to describe the existing relationship between the member and the specialist practitioner. This should include the time in care, and which services are provided. The specialist practitioner will need to provide clinical rationale as well as any supporting documentation.

The specialist practitioner's specialty must be supplied to determine if they have the credentials to support providing PCP services. The specialist practitioner must be board certified and/or have education and training in the field of family medicine, internal medicine, general practice, pediatrics, geriatric medicine, and/or obstetrics/gynecology. The specialist practitioner must also be participating. The specialist practitioner will attest by signature and date that they agree to serve as the PCP for a specific member and will fulfill all the PCP duties described in THP's practitioner contract, Practitioner Manual, and policies/procedures.



The Request Form: Specialist as Primary Care Practitioner can be found on, THP's provider portal at myplan.healthplan.org, or by contacting THP's Customer Service department. Once the member, current PCP, and specialist practitioner completes the Request Form: Specialist as Primary Care Practitioner, it will be submitted to THP Medical Director for review and to approve or deny.

The completed Request Form: Specialist as Primary Care Practitioner, along with the applicable letters, will be sent to the member, the current PCP, and the specialist practitioner. The designation of the specialist practitioner as the PCP for the member will allow the PCP co-payment to be applied for all services rendered by the specialist practitioner.

THP will grandfather any current member who has a specialist listed as their PCP in THP's system as of May 1, 2022. The members and specialist practitioner will not be required to complete the Request Form: Specialist as Primary Care Practitioner; however, the specialist practitioner is still required to fulfill all THP PCP requirements.

Member Wellness, Prevention, & Health Promotion

THP offers primary preventive health interventions to help decrease the incidence or progression of illness and chronic disease. THP engages members in wellness and health promotion activities, such as education, physical activity, and health screenings, to encourage a healthy lifestyle.

THP provides and promotes health risk screening, wellness information, clinical guidelines, and other self-management tools. These tools are available on THP corporate [website](#), secure member portal, or interactively by telephone with a member advocate by calling 1.855.577.7124.

Member Wellness and Prevention and Health Promotion initiatives include:

- Outreach/welcome calls
- Health Risk Screening with risk stratification to clinical program referrals
- Screening/Periodicity Reminders/Gap in Care Closure Notification and education to impact Over and Under Utilization of resources with targeted campaigns
- Family Planning Education, Trimester Screening and Well Pregnancy Education Calls
- Risk Reduction Information related to nutrition, exercise, stress management, home safety/falls prevention, safe opiate use and disposal, etc. provided to population health driven focus groups via health fairs, wellness program, email blasts and targeted campaigns
- Personal Wellness with Certified Health Coaches providing care planning towards individualized goals through engagement in THP CoreWellness Program. Certified Health Coaches can be reached by calling 877-903-7504 Monday through Friday from 8am to 5pm.
- Certified life coaches to assist with self-actualization, inclusive of educational resources/job training, managing finances/budgeting and assistance with family resources. The life coaches may be reached by calling 877-903-7504 Monday through Friday from 8 am to 5 pm.
- Social Determinant of Health (SDoH) screening and resource referrals to outside supports/community-based organizations: Women, Infants and Children (WIC), Food Banks, Birth to Three, Workforce, etc. THP Social Workers may be reached by calling 1.877.221.9295 Monday through Friday from 8 am to 5pm.
- Tobacco Cessation with American Lung Associated certified Freedom from Smoking facilitators. Facilitators can be reached by calling 877-903-7504.



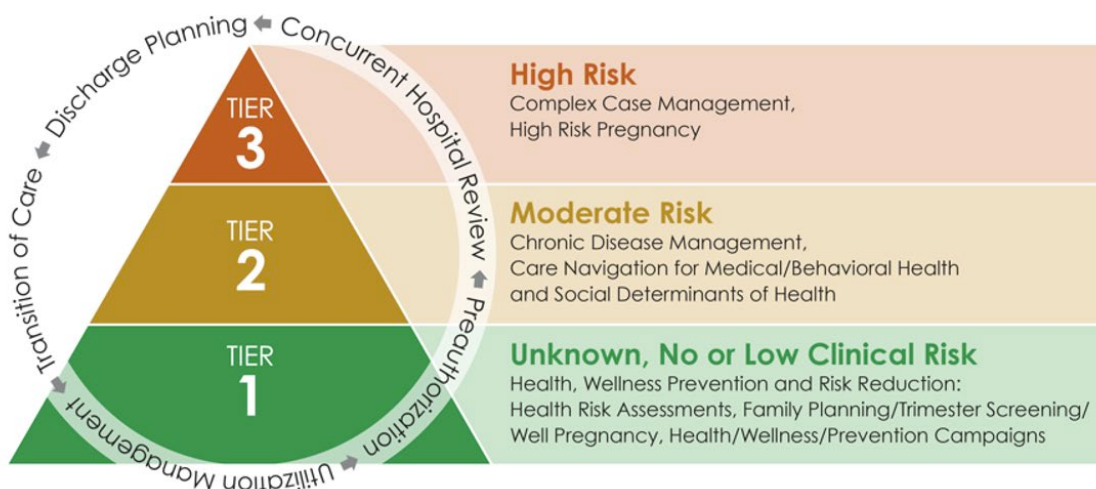
Practitioners may refer members to THP's free Member Wellness, Prevention and Health Promotion or Clinical Programs via our website at <http://www.healthplan.org/providers/resources/physician-case-management-referral>.

Care Coordination

Care Coordination is promoted through a series of supportive services and programs offered to THP members to facilitate quality care planning and improve access to care. Care Coordination is made up of a three- tiered risk-based stratification system that includes opportunities for members to engage in programs based on a Low, Moderate or High-Risk level.

Members with any identified needs related to end of life issues, functional deficits, personal resource deficits, benefit issues, poor linkage to care, caregiver issues, or medication issues to name a few, are appropriate to refer or may self-refer to a care coordination program. THP's clinical analytic tools and health risk assessment results are used to stratify members to a program that is correct for them. Members with high clinical risk and actionable opportunities may be appropriate for Complex Case Management or High-Risk Pregnancy if they are pregnant. Those with less risk but have identified needs may be enrolled in Care Navigation. Members requiring specific education to manage chronic conditions such as diabetes, cardiac, respiratory, or high-risk perinatal conditions may be appropriate for Disease Management or Perinatal Care Programs. Members with low risk or unknown risks may benefit from engagement in Health and Wellness, Prevention and Risk Reduction Programs such as CoreWellness or by receiving information through an educational campaign to aid in prevention or promote wellness and routine screening.

THP Clinical Care Coordination Programs form a pyramid with high-risk members enrolled in Tier 3 Programs at the top of the pyramid and Tier 1 or Health and Wellness programs forming the base of the pyramid. Each program includes educational aspects of the information included in the programs below. For example, Complex case management includes health and wellness/preventive information as well as chronic disease management information for members with relevant diagnoses. Utilization management programs encircle care coordination programs and provide another layer of support and service to provide access and promote comprehensive care across all settings and risk levels.





Care Navigation

Care Navigation is a program for the moderate risk member requiring support or education to achieve personal health goals on a short-term basis. It is intended to be episodic or situational and care is facilitated by a care navigator. Care navigators can be registered nurses, licensed practical nurses, social workers, licensed professional counselors or medically trained member advocates depending on the nature of the case and member's need. A THP care navigator coordinates resources to support members and minimize costs while improving total quality of care. Care navigation focuses on service access, health maintenance, education, and member empowerment through promotion of self-management skills. Medical and behavioral health needs are addressed along with social determinants of health (SDoH) needs to provide the best possible member outcomes.

Complex Case Management

Complex Case Management is a program that helps provide appropriate care and supportive services to high-risk individual members, their families and/or caregivers via a personalized care plan. Members are identified as high-risk due to severity of illness or injury and complexity of services and are enrolled in this program based on a clinical analytic defined risk score comprised of clinical risk and actionable opportunities or a high score on a health risk assessment. Members receive a comprehensive Health Risk Assessment (HRA) and/or disease specific assessment performed by a complex case navigator to develop a member centric care plan. Assessments are performed on enrollment and at minimum annually for as long as the case remains open. Complex case navigators are registered nurses with Certified Case Manager credentials (CCM), or they are registered nurses supervised by a CCM. They have a variety of specialty backgrounds and are trained to address medical, behavioral, and social needs.

A key aspect of the Complex case navigator's job is to assess the needs of the member from a holistic point of view. A comprehensive assessment helps identify any potential medical/behavioral health needs, safety needs, gaps in care or applicable social determinants of health such as housing or food security that must be addressed in a care plan to help the member to achieve defined goals. Opportunities, goals, and interventions are identified and agreed upon by the member in collaboration with the complex case navigator and their care team members. Care team members may include pharmacists, social workers, counselors, psychologists, THP medical directors, practitioners and/or family members/caregivers identified by the member or the Complex Case Navigator and added to the care team. The Complex case manager serves as the direct contact to coordinate care with all involved care team members and is responsible for scheduling follow up calls and/or visits at routine agreed upon intervals to guide care coordination along with the primary care practitioner. Timing of interventions and call frequency is based on individual need, member acuity and agreed upon schedule of interventions.



Complex Case Examples May Include:

- Transplants—organ and bone marrow/stem cell; includes evaluations, pending and post transplants
- Catastrophic neuromuscular diseases such as multiple sclerosis, myasthenia gravis, amyotrophic lateral sclerosis
- Brain injury in active treatment
- Cystic fibrosis
- New spinal cord injury
- 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
- Immunodeficiency
- Ventilator cases in home setting
- Major congenital anomalies – atrial septal defect, valve stenosis and atresia, pulmonary artery stenosis, patent ductus arteriosus, craniofacial deformities, myelocystocele, myelomeningocele (such as spina bifida)
- Premature birth (extreme) 28 weeks or less
- Complex cancers in active treatment; with anticipated ongoing high-cost care, including myelodysplasia
- Children with special health care needs (CSHCN)
- Hemophilia
- Genetic abnormality with ongoing care, treatment, or monitoring
- Trauma – Complex needs in active treatment
- Serious and persistent mental illness as evidenced by recurrent non-substance use related psychosis or mania with multiple emergent admissions



Chronic Disease Management Program

Chronic Disease Management (CDM) is an education and support program developed to proactively identify populations with, or at risk for, chronic medical conditions. Populations currently being managed include members with diabetes, chronic cardiac conditions such as coronary artery disease, congestive heart failure (CHF), and chronic obstructive pulmonary disease (COPD) or asthma. The focus of chronic disease management is early identification and educational engagement with a nurse navigator for newly diagnosed or risk-based members to learn life skills needed to prevent disease progression and knowledge to support self-management. THP CDM Program also uses a remote patient monitoring (RPM) vendor for additional support for appropriate members. The RPM program is tablet-based educational materials and surveys with attached digital monitoring tools that include blood pressure cuffs, pulse oximeters, scales and glucometers as appropriate based on the member's condition for enrollment. The RPM vendor shares biometric information of concern with THP CDM staff and the treating practitioner.

The CDM Program supports the practitioner-patient relationship and plan of care and emphasizes the prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies.

Program Content

- The program includes condition monitoring relevant to the identified disease state or states that is ongoing and proactive.
- Member adherence to the practitioner treatment plan is integral. Members are followed to determine their success with self-management, self-monitoring activities, and medication compliance. Practitioners are made aware of their members enrollment in the program, and information is shared with practitioners on the Care Team. 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.
- Member education is targeted at areas of concern based on the findings from a clinical assessment and functional inventory which is used to build a care plan. Ongoing monitoring 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 severity of symptoms. This may result in daily contact at times of elevated risk or concern.
- Closure of care gaps is a program goal, and Disease Management Nurse Navigators work collaboratively with members and practitioners to facilitate preventive screens, routine tests and recommended ongoing monitoring related to disease states.

Members are stratified to Disease Management Programs based on the Impact Pro Population Health Category of Chronic Big Five Conditions, identified needs, moderate health risk assessment scores, a moderate clinical risk score, actionable opportunity levels, and their propensity to engage as well as members identified with newly diagnosed Chronic Big Five Conditions.

THP's Chronic Disease Managers may be reached by calling 800-776-4771 Monday through Friday from 8 am to 5pm.



Family Planning, Well Pregnancy, and High-Risk Pregnancy Programs

Family planning, well pregnancy and high-risk pregnancy programs are designed to improve access to family planning, early and routine prenatal care, improve pregnancy outcomes, reduce neonatal hospitalizations, and reduce costs associated with pre-term birth and other complications of pregnancy. This is accomplished by providing education for family or pre-pregnancy planning, perinatal education, promoting safe health behaviors, and enhancing the management of care for women identified as interested in family planning, planning for a healthy pregnancy, pregnant and well or currently identified as high-risk for premature labor and delivery. The Family Planning, Well Pregnancy and High-Risk Pregnancy Programs are administered by THP Perinatal Nurse Navigators with a background in Obstetrics, Gynecology, Labor/Delivery/Post-Partum Recovery or care of neonates.

Program Goals:

- 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
- Early Identification of Substance Use Disorder in Pregnancy and Referral to Appropriate Treatment Support
- Provision of improved family planning and perinatal education, promotion of safe health behaviors including depression screening, and enhanced management of maternity care for women identified as high-risk for premature labor and delivery

Program Enrollment

- Referrals may come from a practitioner, , annual HRAs, Monthly Comment Files, PRSI reports, self-referral, and claims data. Practitioners are provided with a perinatal risk screening tool (PRSI) to complete and return to THP
- The targeted time for member enrollment is during pre-pregnancy planning or early in pregnancy depending upon the program of interest
- Early pregnancy is defined as between 12 to 15 weeks gestation for the perinatal program. A telephonic assessment of the clinical and psychosocial status, including depression screening, of the member is completed by Perinatal Nurse Navigator at enrollment, during each trimester and during the postpartum period
- Family planning members are engaged until their personal care goals are reached by achieving a healthy pregnancy or obtaining appropriate birth control or family planning
- Consideration is given to other health conditions during care planning for Family Planning, Well and High-Risk Pregnancy Programs



- For pregnant members, the assessment tool, along with the perinatal risk screen completed by the practitioner, is reviewed by the 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 dependent on identified risk factors. Relevant information is shared, and care is coordinated with involved practitioners including PCP and obstetricians throughout the program
- 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
- Members in well and high-risk pregnancy programs are provided with education and self-management tools to promote parenting and newborn care during the postpartum period

A successful perinatal care program is dependent on the coordination of health care services. The role of the practitioner is vital, and this program is intended to complement the medical care the member receives from the practitioner. THP's goal is to foster a relationship between the practitioner and the Perinatal Nurse Navigator to coordinate the necessary health care and promote a healthy mother and a healthy baby.

THP's Perinatal Program Case Managers may be reached by calling 877-236-2288 Monday through Friday from 8 am to 5 pm.

What the Member and Practitioner May Expect with Care Coordination Program Enrollment

- Members are identified by risk level and offered the opportunity to engage in a relevant care coordination program. A Care/Nurse Navigator performs a telephonic assessment to determine the member's specific needs and opens a case
- The member receives an introductory call and letter explaining the program. The practitioner receives a copy of the member letter
- A care plan is established based on the member assessment. The care plan identifies prioritized opportunities, goals, and interventions to facilitate personal goal achievement
- A Care Team may include the member, their designated representative, and relevant practitioners. The member has control over who is on their external care team
- Agreed upon interventions are carried out by the care team members as discussed during phone interactions and documented in the care coordination platform
- Agreed upon interventions are carried out by the care team members as discussed during phone interactions and documented in the care coordination platform
- Telephonic reminders are set at agreed upon intervals. Interventions may take the form of providing education, facilitating practitioner appointments, coordinating transportation, explaining benefits, referring to community agencies, transitional care support, caregiver resources, medication adherence and medication reconciliation among others.
- A care coordination program may be closed when:
 - All goals are met
 - Member chooses to terminate participation in care coordination



- o Member becomes non-compliant with the program and no longer participates in calls and interventions. All care coordination programs require a member opts into the program and remains actively engaged throughout the course of the program

Advance Care Planning

Advanced Care Planning allows for effective communication between practitioners and members to plan for the member's future care.

Practitioner's Role:

Practitioners should ask members over the age of 18 if they have an advanced directive and document the information in the member's medical record. If the member does not have an advance directive, it should be noted in the medical record, and the practitioner and office staff should encourage discussions with the member to help them understand advance directives and the importance. . Practitioners should provide members with educational material regarding advance care planning and 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.

Practitioners should transfer any member whose advance directive you cannot support based on moral or religious beliefs that may prevent full support of the member's decision.

Compliance with advance directive policies is part of THP's quality review process. Annual audits are conducted to ensure compliance.

To comply, all members of THP 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 (3) years.

Information regarding advance directives is provided by THP at the time of the member's initial enrollment and is included in their welcome packet. In addition, advance directive information for all 50 states is available on THP's corporate website at healthplan.org.

THP partners with Five Wishes to provide education regarding advance care planning to members. The Five Wishes document is available in print and online formats and can be provided by the practitioner's THP Practice Management Consultant (PMC) upon request or sent to members by calling THP Health Coaches at 877-903-7504 Monday through Friday from 8 am to 5 pm.

Clinical Leadership and Committees

THP's Chief Medical Officer (CMO) and Medical Directors 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 (1) of THP's physicians serves as chairman for each of the following committees:

- Utilization Management Committee (UM Committee) Appeal and Grievance Committees
- Quality Improvement Committee
- Professional Review Committee



THP's medical directors are responsible for all utilization management decisions not delegated to an outside vendor, i.e., denial of prior authorization decisions based on medical necessity. They will communicate with primary care practitioner (PCP), attending practitioner, and specialist reviewers as necessary for case discussions.

THP's medical directors' other responsibilities include:

- Decision making regarding medical appropriateness of care and services
- Review of appeals
- Physician education regarding practice patterns

Utilization Management Committee

The Utilization Management Committee exists to promote the effective implementation of THP Utilization Management program and to provide oversight of the development and maintenance of the scope and processes of prior authorization, concurrent review, and post service reviews.

The committee also ensures that all utilization management functions are sufficient to effectively analyze and make recommendations relating to controlling costs, mitigating risk, and assuring quality of care. This includes the review of utilization patterns and trends through data analysis to detect and recommend remediation of over/under or inappropriate utilization.

The Utilization Management Committee is formed through the combination of two pre-existing committees known as the Medical Director Oversight Committee and Physician Advisory Committee in order to fulfill the internal and external requirements

Membership

The committee is comprised of internal and external members including THP's staff, medical directors, and the Chief Medical Officer, who serves as an advisor to the committee, and:

- Include a majority of practicing physicians.
- Include at least one practicing physician who is independent and free of conflict relative to the plan.
- Include at least one practicing physician who is a specialist in geriatrics.
- Include members representing various clinical specialties to ensure a wide range of conditions are considered in the development of UM policies.
- Include at least one (1) member with expertise in health equity.
- Other people by invitation. Such invitation-only attendees should have a clearly defined purpose for attendance. Such attendees are not intended to offer commentary on other agenda topics outside of the reason for their attendance and shall be excused when the purpose for their attendance has concluded. Subject matter experts (SMEs) may be invited by the committee for a specific agenda topic and shall only participate during the related topic.



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 THP Commercial, MHT 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 or practitioners are dissatisfied. THP's medical director has the final decision-making authority.

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 THP membership. The committee's composition includes practitioners, pharmacists, and representation from THP. The Pharmacy and Therapeutics Committee reports quarterly to the Quality Improvement Committee.

Quality Improvement Committee

The Quality Improvement Committee responsibilities include recommending policy decisions, analyzing and evaluating the results of QI activities, ensuring practitioner participation in the QI program through planning, design, implementation, and review, identifying needed actions and ensuring any follow-up as appropriate. The committee:

- Recommends and revises, or oversees recommendations and revisions to, policies for effective operations of the QI program and achievement of the QI program objectives
- Oversees the analysis and evaluation of the QI program and assesses the results
- Facilitates participating practitioner involvement in the QI program activities through attendance and discussion in relevant QI committee or QI subcommittee meetings or on ad hoc task forces
- Identifies actions to improve quality, prioritizes them based on their significance and choose which to pursue, or oversees these functions if performed by an associated committee or subcommittee
- Reviews and evaluates THP's actions to determine effectiveness

Professional Review Committee

The Professional Review Committee (PRC) serves as the peer review committee responsible for reviewing all information available regarding practitioner credentials as well as character, professional competence, qualifications, and ethical standing of applicants for privileges as practitioners of THP. This committee is also responsible for investigating any breach of ethics reported to the committee, propose changes or restrictions in privilege status, and recommend or reject new appointments and reappointments.



Annual Utilization Management Program Description and Evaluation

An annual written Clinical Service UM program evaluation that includes the Medical, Behavioral Health, Pharmacy and Appeal & Grievance Units is prepared in collaboration with Clinical Service management staff. The evaluation includes data from the work plans which include barriers encountered, opportunities for improvement, final analysis, and recommendations for the upcoming year. The evaluation is complete after applicable recommendations are received from the UM work group, Continuous Quality Improvement work group, and approved by the Medical Directors Oversight Committee (MDOC).

Once the UM program evaluation is finalized by MDOC, the recommendations are incorporated into a revised annual UM Program Description for the upcoming year.

The finalized Utilization Management Program Description is effective after the Statement of Approval is completed by the MDOC representative and the CMO.

Medical Economics

THP's medical economics team identifies and stratifies THP enrollment population based on medical conditions, risk factors, and social determinants of health (SDoH).

Data is reviewed to assist in developing programs to meet the needs of various risk groups and engage both members and practitioners in improving the overall health of the populations.

The medical economic 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
- Managing 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. Information obtained from health risk assessments is analyzed to identify social determinants of health (SDoH) and barriers to care. Electronic health records (EHR) may be available through shared portal access with practitioners. Other data points include clinical assessments performed by THP's Clinical Services Department nurse navigators, member outreach, and vendors that provide in-home assessments. Data available through licensed software is incorporated into the analytical process.

The population assessment is completed to determine:

- Needs across THP service area
- Members that should be targeted for various care navigation programs
- Appropriateness for 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 and member satisfaction with clinical services programs. Data is reported in aggregate and by line of business 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 SDoH that are identified as barriers to care include:

- Transportation and/or lack of transportation
- Mobility issues
- Food insecurity
- Social isolation

Quality Measures and 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. THP is required to report quality performance measures set forth by HEDIS, to NCQA, CMS, and BMS annually. The HEDIS audit takes place annually between January and June and claim data is used when applicable. THP contracts with an outside vendor to assist with medical record retrieval needed for each of the applicable performance measures. THP's vendor may contact practitioners for chart retrieval. THP will coordinate an onsite visit to accommodate the practitioner and office staff.

To support performance measurement, care gap reports to identify members with gaps in care according to HEDIS quality measures specifications are available through the secure provider portal. Gap reports are run monthly based on a proactive review of members' claim history.

Coding by measure is outlined in the Quality Measures and HEDIS Coding Guide that is available on THP's corporate website.

In addition to utilizing care gap reports and the appropriate HEDIS related ICD-10 codes to capture the services rendered, practitioners can submit clinical documentation for HEDIS measures via fax to THP at 740.699.6163. A documentation cover sheet is required and can be found on the provider portal resource library.

Chapter 10

Pharmacy





Introduction

The Health Plan (THP) promotes optimal therapeutic use of pharmaceuticals by encouraging the use of cost-effective generic and/or brand drugs in certain therapeutic classes.

THP has processes in place that explain how members, pharmacists, and practitioners determine which medications are covered under members' benefit, any utilization management requirements and where members can fill medications.

THP publishes a prescription formulary at least annually for Commercial (including Exchange plans), Medicare Advantage and Self-Funded/Administrative Services Only (ASO) lines of business on the corporate website at healthplan.org. The formulary indicates a drug's copay tier and utilization management requirements including prior authorization, step therapy, or quantity limit requirements.

THP has drug policy coverage criteria to encourage the use of preferred drugs in the therapeutic class for the treatment of certain diseases. THP publishes the drug policy coverage criteria for Commercial, (including Exchange plans), Mountain Health Trust (WV Medicaid), and Self-Funded/ASO lines of business on the provider portal at myplan.healthplan.org → "Policies." Drug policy coverage criteria for Medicare Advantage is published under Additional Resources on the Medicare portion of the corporate website at healthplan.org → "Medicare" "Quality Assurance and Utilization Management." Select drugs require prior authorization based on specific plan requirements.

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 Food and Drug Administration (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.

THP 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.

Prescriptions can be filled at any participating THP pharmacy within the member's pharmacy network. Where allowed by [Freedom of consumer choice for pharmacy](#) (WV House Bill 4112), THP reserves the right to redirect medications to a specific pharmacy such as a specialty pharmacy for certain medications. Any medication redirection will be communicated to practitioners via the prior authorization notification letter.



Clinical Criteria for Pharmaceutical Management Program

THP utilizes both external clinical vendor and internal utilization management policies to perform medical necessity reviews for pharmaceuticals. Drug policy coverage criteria is developed based on reasonable medical evidence and guidelines using one (1) or more of the following:

- FDA label literature, national accepted treatment guidelines, and/or standard medical reference compendia adopted by the United States Department of Health and Human Services.

Additional factors take into consideration include:

- Individual member circumstances and medical history, West Virginia Bureau for Medical Services (BMS) Preferred Drug List, Coverage Details and Criteria/Policy Manual (for WV Medicaid policies only), preferred covered drugs for the condition, preferred formulary agents in the drug class and cost analysis.

Policies are reviewed at least annually by the clinical vendor or THP using the above development criteria and additional factors. Recommendations are reviewed by Pharmacy and Therapeutics Committees.

Pharmacy and Therapeutics Committee

The Pharmacy and Therapeutics (P&T) Committee serves as an advisory committee responsible for providing multi-disciplinary oversight and review of new and evolving pharmaceuticals for possible inclusion in the benefit structure for THP's pharmaceutical management program. The P&T Committee also works to ensure compliance with FDA label literature, national accepted treatment guidelines, standard medical reference compendia adopted by the United States Department of Health and Human Services and state and federal regulations.

Specialty Pharmacy Program

Specialty drugs are used to treat complex, chronic conditions and/or rare diseases. Extensive management for safety and effectiveness is often needed along with dosage monitoring and adjustment for optimal treatment of the member's condition.

Specialty drugs require prior authorization to ensure appropriate utilization of the drug. Dispensing may be limited to pharmacies with specific services and distribution programs to ensure proper management and 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.

To verify if a medication is considered a specialty drug, please refer to the [formulary](#) (list of covered drugs). Specialty drug names will be followed by "SP" for specialty drug and listed as tier 4, 5, or 6 in the formulary.



Pain Management Program and Opiate/Opioid Management

THP 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 7-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 THP members that need further pain management, a prior authorization will be required if the opioid:

- Exceeds 80 morphine milligram equivalents
- Is taken for greater than 90 consecutive days
- Is long acting
- Use of more than one immediate release and one extended-release opioid

A clinical pharmacist will review the coverage review to evaluate that the opioid is being utilized in accordance with the utilization management policy. Additionally, if necessary, the member can be limited to one (1) prescriber and one (1) pharmacy.

Formulary medications will be preferred over non-formulary medications. Step therapy rules may be applied when reviewing a request for non-formulary medications. Also, dosing and quantities may be limited. If the prescribing practitioner does not bill THP for services, no coverage of opioids will be provided through the pharmacy benefit.

Prescribers issuing controlled substances to MHT members must review the WV PDMP in accordance with Section 5042 of the SUPPORT Act prior to issuance. In the case that a prescriber cannot check the PDMP despite a good faith effort by the prescriber, the prescriber must document such good faith effort, including the reason(s) why the prescriber was not able to check the PDMP. Prescribers may be required to submit, upon request, such documentation to BMS.

THP's Pharmacy Network

THP members may obtain prescriptions at any participating THP pharmacy. For the location of a participating pharmacy, contact Express Scripts, THP's prescription benefit manager at 1.800.988.2262 or [express-scripts.com](https://www.express-scripts.com). The member's THP ID card must be presented to the pharmacy. The member may be required to pay a copayment based on their prescription drug plan.



Formulary

THP formularies are a listing of prescription medications that are preferred for use. Formulary drugs will be a covered benefit when dispensed at participating pharmacies. Non-formulary drugs are not covered without an approved coverage determination from THP. Coverage requests may be requested.

Choosing a Preferred Drug Formulary

Formulary Tier Definitions

- Prescription – Drugs that can only be dispensed upon order (prescription) by a qualified practitioner 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 practitioner 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

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. Where state pharmaceutical dispensing laws permit, the pharmacy is encouraged to dispense generic forms of prescribed drugs. Failure to dispense the generic will subject the member to a higher copayment consisting of the brand copayment plus the cost difference between the brand and 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 THP cost of a brand name and its generic equivalent i.e., THP only pays for the generic cost. Non-formulary brand versions of generic drugs require coverage review.



Non-Formulary Requests (Exception Policy)

Certain non-formulary medications are eligible for coverage only after a member-specific approval has been prior authorized. Member-specific criteria may include age, gender, and clinical conditions determined by the practitioner for authorization to be granted for a specific drug. A non-formulary exception request can be made by the member, member's representative, or practitioner. A Formulary Exception Request Form may be accessed at myplan.healthplan.org or by contacting Pharmacy Services.

THP 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 at 1.800.624.6961, ext. 7914.

Requests will be reviewed according to the following criteria:

- The request for the non-formulary drug is for a condition or medical need not met by existing drugs on THP formulary
- In the practitioner'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)
- 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)

Prior Authorization for Coverage

Prior authorization for coverage consists of criteria-based programs for determining whether members qualify for coverage of a requested drug based upon the plan's drug policy coverage criteria. Drug policy coverage criteria are based on recommendations of the Pharmacy and Therapeutics Committee. These criteria are periodically reviewed for alignment with FDA label literature, national accepted treatment guidelines, Standard medical reference compendia adopted by the United States Department of Health and Human Services and state and federal regulations.

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, THP will cover the maximum allowable cost of the generic. 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 pharmacy will transmit a claim to THP. If the item submitted is available as a generic, THP returns the cost of the prescription in the following manner:

Brand submitted	Generic submitted
The brand copay is assessed + the difference in the cost of the generic and brand product to arrive at a brand penalty copayment. Copay = brand copayment + penalty	The generic copayment is assessed, and it is the member's responsibility to pay at the time of dispensing

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.

The requests must include:

- Supporting medical literature describing treatment failures of the generic
- 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

Pharmacy Prior Authorizations

THP's Pharmacy Services Department assists with member coverage, eligibility and prior authorization requirements. THP's medical pharmacy prior authorization requirements can be found on THP's secure provider portal at myplan.healthplan.org and corporate website at healthplan.org.

Traditional Prior Authorization (TPA)

THP Pharmacy Services Department adjudicates coverage review determinations and prior authorization updates. Traditional prior authorization criteria are developed and conform to plan coverage conditions for client review and selection and in administering prior authorization policies. Traditional prior authorization rules require coverage review for all claims presented for a given drug to determine if the member meets drug policy coverage criteria.



Smart Rules – Automated Prior Authorization Processes at the Point of Sale

Smart rules in pharmacy benefit manager's system use sophisticated logic in conjunction with available drug history, member reported health information, and medical claims information to automatically determine whether a member qualifies for coverage of a drug based on the plan's drug policy coverage criteria. As a result, smart rules limit coverage reviews to only those claims where the member's information is least likely to meet drug policy coverage criteria.

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 most members. Drugs that are subject to quantity per dispensing event rules usually have specific quantity limitations approved by the FDA. Through traditional prior authorization, members can be approved for an additional quantity limit exception.

Chapter 11

Quality





Introduction

The Health Plan (THP) 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 (DOI).

THP Quality Improvement Program consists of clinical and service components necessary to improve the quality and safety of member care.

The clinical component objectives include preventive care, acute care, chronic care, population health management, and care for special needs populations. The program description monitors compliance, health outcomes, health initiatives and health education, clinical practice guidelines, member experience, credentialing, delegation, and medical record audits.

The service component objectives monitor availability and accessibility, and member and practitioner experiences through the lens of surveys, complaints, and appeals.

The Quality Improvement Program ensures that members' and practitioners' needs are met, and continuous quality improvement is ongoing at THP.

The Quality Improvement Program is evaluated annually for its effectiveness. Barriers and opportunities for quality improvement are identified and are worked into future focus groups and/or initiatives.

The PDSA (Plan-Do-Study-Adjust) Cycle is utilized throughout the Quality Improvement Program when initiatives are taken into consideration. The PDSA Cycle is essential in understanding the impact of the interventions established for the initiatives.



Goals and Objectives

1. Demonstrate compliance with the following:
 - National Committee for Quality Assurance (NCQA)
 - Centers for Medicare and Medicaid Services (CMS)
 - Qlarant - External Quality Review Organization for WV Department of Health Services (DoHS)
 - West Virginia Office of Insurance Commissioner (WV OIC)
 - Ohio Department of Insurance (ODI)
2. Monitor and improve continuity of care between practitioners and across practitioner settings
3. Establish standards and processes for measuring and improving the quality of care and services provided to members through:
 - Peer Review Processes
 - Medical Record Audits
 - Surveys: Consumer Assessment of Healthcare Providers and Systems (CAHPS), Medicare Health Outcomes Survey (HOS), Experience of Care and Health Outcomes for Behavioral Health (ECHO), Provider Satisfaction Surveys
 - Clinical Care
 - Medical/Surgical Potential Deviations in Care
 - Behavioral Health Potential Deviations in Care
 - Medicare Advantage, West Virginia Mountain Health Trust (West Virginia Medicaid, and WV Children's Health Insurance Program) and/or CMS driven clinical reviews which include:
 - Never Events (NE)
 - Hospital-Acquired Conditions (HAC)
 - Health Care-Associated Conditions (HCAC)
 - Provider Preventable Conditions (PPC) and other Provider Preventable Conditions (OPPC)
 - Key Performance Indicators (KPI) to ensure maintaining and exceeding established performance benchmarks
 - Performance Improvement Projects (PIPs)
4. Provide a platform for members and practitioners to express concerns regarding care and service experience:
 - Quality of care
 - Access to care
 - Customer Service
 - Billing/Financial Service by THP
 - Quality of practitioner office site
5. Implement initiatives to improve health care outcomes and clinical safety using evidence-based guidelines and resources



Clinical Care Quality Indicators

The Quality Improvement Department monitors quality of care concerns centered on evidence-based guidelines through a root cause analysis conducted by Quality & Performance Improvement Nurse Coordinators.

THP follows but is not limited to the following evidence-based guidelines:

- Agency for Healthcare Research and Quality (AHRQ) for PSI 90 Member Safety Indicators
- National Healthcare Safety Network (NHSN) for healthcare-associated infections
- National Quality Forum (NQF) for serious reportable events

CMS Star Ratings

The Centers for Medicare & Medicaid Services (CMS) evaluates Medicare Advantage (MA) and Prescription Drug (MA-PD) plans using a star rating system. The CMS Five-Star Quality Rating System provides helpful information to consumers, families, and caregivers for comparing MA-PD plans based on a one-to-five rating:

- 5. ***** = excellent
- 4. **** = very good
- 3. *** = good
- 2. ** = fair
- 1. * = poor

Many measures included in the CMS rating system are preventive care and routine disease management.

For example:

- Staying healthy — screening, tests, and vaccines:
 - Breast cancer screening
 - Colorectal cancer screening
 - Annual flu vaccine
 - Improving and maintaining physical and mental health
 - Monitoring physical activity
- Managing chronic conditions:
 - SNP Care Management – Care for the older adult: medication review, functional status assessment, and pain screening
 - Managing osteoporosis in women who had a fracture
 - Obtaining diabetes care for eye exams, kidney disease monitoring, and blood sugar and cholesterol control
 - Controlling blood pressure
 - Improving bladder control
 - Reducing the risk of falling
 - Plan all-cause readmissions
 - Medication adherence and management (oral diabetics, hypertension, and cholesterol medications)



Practitioner Expectations

The Quality Improvement Committee (QIC) provides governance, oversight, and expertise in the review of health outcomes and appropriateness of care and utilization with objective evaluations of member care and experiences to promote enhancements and improvement in the quality and safety of clinical care and services provided.

THP's Quality Improvement Committee (QIC) identifies expectations and behaviors for THP participating practitioners.

Practitioners are expected to cooperate with THP's QI activities to improve the quality of care and services and member experience. Cooperation includes timely collection and evaluation of performance measurement data and participation in Quality Improvement programs. THP may use performance data for quality improvement activities.

Additional requirements include cooperation and engagement with potential quality of care root cause analyses, member complaints/grievances, and any review or reporting requirement including state or federal agency with authority i.e., National Committee for Quality Assurance (NCQA), Healthcare Effectiveness Data Information Set (HEDIS).

Practitioners are required to provide medical records to THP in a timely manner to meet regulatory requirements. This includes medical records needed to support risk adjustment and quality improvement initiatives.

THP is responsible for implementing procedures for reducing, suspending, or terminating a practitioner's participation for reasons relating to quality of care, competence, or professional conduct. Remedial action plans will be developed within 30 days of identification of the systemic problem. Corrective Action Plans may be instituted for any treatments, procedures, or services which indicate a practitioner is not practicing medicine in a manner that follows reasonable and prevailing standards of care or medical ethics. This may be identified through complaints, QI activities, failure to maintain adequate medical records, failure to provide adequate care or after-hours care.

Corrective actions may vary according to the situation and may include but are not limited to one (1) or more of the following as they relate to treatment, procedure, and service:

- Written warning to the practitioner
- Discussion with the practitioner
- Placing the practitioner under a focused review via medical review or reviews generated by claims data at scheduled intervals; results reported to the Quality Improvement Committee (QIC) who will direct further action of the corrective action plan
- Requiring the practitioner to enter a preceptor relationship with another practitioner, whereby the practitioner acting as the preceptor would monitor and observe the practitioner subject to corrective action, including examining medical records and interaction with members
- Requiring the practitioner to complete continuing medical education regarding treatment, procedure, or service in question
- Limiting the practitioner's privileges i.e., limiting the authority to perform certain procedures
- Recommendation for recredentialing on a shorter cycle
- Recommendation for contract termination



Final determination resulting in corrective action will be communicated to the practitioner in writing, setting forth the type and nature of the corrective action to be taken. Any corrective action will be monitored for compliance at intervals determined by the Quality Improvement Committee. The practitioner will be notified of the results of such monitoring and will be made aware of the termination or continuation of any corrective action as recommended by the QI Committee.

Continuity and Coordination of Care

THP supports the partnership of members and primary care practitioners to ensure continuity and coordination of care. THP's continuity and coordination of care policy specifies the following responsibilities:

- All practitioners involved in a member's care must share clinical information with each other and the member in a timely manner. Most referrals to specialty care should be submitted by the PCP. Treatment plans should specify an adequate number of direct access visits to specialty care to accommodate the treatment plan's implementation. Members are afforded direct access to behavioral health practitioners. All referral notifications will include a reminder to all parties to share clinical information in a timely manner
- Practitioners must document member input in all treatment plans submitted
- THP does not prohibit a health care professional from advising and advocating on behalf of a member
- Practitioners should provide information about the findings, diagnoses, and treatment options regardless of coverage, so the member can decide among all relevant treatment options
- Practitioners should provide members with information about risks, benefits, and consequences of treatment or non-treatment. Members should be provided with a choice to refuse treatment and discuss their preferences about failure of treatment decisions

Practitioner Availability Standards

THP has practitioner network adequacy standards that include adult and pediatric standards for PCPs and specialists, obstetricians/gynecologists, basic hospital services, tertiary hospital services, pediatric and adult dental practitioners behavioral health practitioners and facilities, substance use disorder (SUD) practitioners and facilities, and PRTFs.

Practitioners must ensure hours of operation are convenient, do not discriminate against members and have no less than hours of operation offered to commercial members or comparable to Mountain Health Trust (WV Medicaid and CHIP) members.

Practitioners cannot discriminate against MHT and WV CHIP members in the order that members are seen or appointments are given.



Screening for Behavioral Health Needs

THP encourages PCPs to assess members of all ages for behavioral health needs. If practitioners need assistance with a referral to a behavioral health specialist, contact THP's Behavioral Health Department at 1.877.221.9295 for assistance.

THP suggests the following when encountering a member who may be experiencing problems with substance use disorders:

- Ask about substance use and screen for problem use
- List the member's diagnosis in the medical record
- Refer to a qualified behavioral health clinician, when necessary
- Encourage the member to follow through
- Express interest in their progress

Practitioner Self Care/Treatment and/or Family Care/Treatment

THP follows American Medical Association (AMA) recommendations that practitioners should not treat themselves, their immediate family members, or their household members.

However, it may be acceptable to do so in limited circumstances such as:

- In emergency settings or isolated settings where there is no other qualified practitioner available
- For short term, minor problems
- Except in emergencies, it is not appropriate for practitioners to write prescriptions for controlled substances for themselves or their immediate family members

When treating self or family members, practitioners have a further responsibility to document treatment or care provided and convey relevant information to the member's PCP.



Practitioner Access Standards

Primary Care Practitioners (PCP)	
Routine Care	Within 15 business days
Urgent Care	Within 24 hours
Emergent Care	Immediately or referred to an emergency facility
Behavioral Health	
Routine Care	Within 10 business days
Urgent Care	Within 6 hours
Emergent Care	Immediately or referred to an emergency facility
OBGYN	
Routine Prenatal Care	Within 14 calendar days of the date the member is found to be pregnant
Routine Care for OB members or Non-OB Members	Within 15 business days
Urgent Care	Within 24 hours
Specialty Care	
Routine Care	Within 20 calendar days
Urgent Care	Within 24 hours

Mountain Health Trust only:

- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services must be scheduled in accordance with EPSDT guidelines and the EPSDT Periodicity Schedule
- THP encourages members with Mountain Health Trust - Supplemental Security Income (SSI) to schedule an appointment with a PCP or specialist who manages the member's care within forty-five (45) calendar days of initial enrollment. If requested by the member or practitioner, THP schedules or facilitates an appointment with the member's PCP.

After Hours Accessibility

Practices are required to be available to THP members through on a call practitioner, answering service, or voice mail message directing the member to the Emergency Room if the case is emergent.

Chapter 12

Credentialing and Data Management





Credentialing

The Health Plan (THP) is accredited by the National Committee for Quality Assurance (NCQA) and is required to adhere to NCQA standards. In addition, THP is required to comply with credentialing standards set forth by the states of West Virginia and Ohio, West Virginia Mountain Health Trust (MHT) and the Centers for Medicare and Medicaid Services (CMS). Practitioners wishing to provide services to THP MHT members must enroll with Medicaid Management Information System (MMIS), the state of West Virginia's fiscal agent, prior to rendering service(s).

Practitioners wishing to provide services to THP Medicare Advantage members must enroll with CMS prior to rendering services.

Practitioners participating in THP's practitioner network must comply with all applicable federal, state, and/or local law, rules, regulations, and standards, including but not limited to licensure, certification, accreditation, and registration requirements. It is the practitioner's responsibility to ensure they meet all legal and regulatory requirements with which the practitioner must comply.

Failure to comply may result in corrective action by THP, including but not limited to contract termination, termination of other rights and/or privileges, and/or claim denials or recoupments. ,

THP follows an established process to credential practitioners. Information submitted to THP as part of the credentialing process is verified in accordance with the procedures listed below. Applicants and their practices are evaluated based on certification standards developed and approved by THP's Professional Review Committee (PRC). Credentialing and recredentialing are conducted in a fair and non-discriminatory manner. THP does not discriminate regarding network participation or reimbursement against any practitioner acting within the scope of their license or certification.

For Mountain Health Trust (MHT) practitioner credentialing, THP shall utilize the standard credentialing application form prescribed by the WV Offices of the Insurance Commissioner, in collaboration with The Council for Affordable Quality Healthcare (CAQH). THP may not require the practitioner to provide any information in addition to the information required by the standard form. This does not include requests for clarification, the completion of missing or incomplete information, or the submission of supporting documentation related to the information submitted on the credentialing application. Practitioner credentialing applications, renewals, documents and supporting materials submitted by practitioners must be submitted electronically.

Initial Credentialing

The initial credentialing process requires the completion of The Council for Affordable Quality Healthcare's (CAQH) online application and the completion of primary source verifications by THP, and if applicable, an onsite office site visit. Practitioners must authorize THP to access CAQH data to facilitate the credentialing process.

Primary source verification of (but not limited to):

- Active Licensure in state where services are provided
- Clinical Privileges at a participating THP hospital
- Active DEA in the state where services are provided
- Five-year work history
- National Practitioner Data Bank (NPDB)
- Board certification(s)
- Medical education and training



An on-site office site visit will be completed on the following practitioner types who service THP Commercial and/or MHT members, unless the practitioner has joined an office location that has previously had a THP site visit completed:

- Primary Care Practitioner (PCP)
- Behavioral health practitioners
- High volume/high impact specialties

Recredentialing

THP recredentials practitioners according to the credentialing requirements set forth by NCQA, the states of West Virginia and Ohio, West Virginia Mountain Health Trust (MHT) and CMS. THP also reviews quality of care issues and member complaints at the time of recredentialing. Practitioners are credentialed at least every 36 months.

Practitioner's Credentialing and Recredentialing Rights

Right to Review Credentialing/Recredentialing Information

Practitioners have the right to review information submitted in support of the credentialing/recredentialing application. To request a review, please contact THP at 1.800.624.6961. Upon request, THP will provide a copy, sent by certified mail, of the credentialing application and primary source verification documents received during the most recent credentialing or recredentialing cycle. Practitioners will not have access to protected peer information, references, or recommendations as part of the review process.

Right to Correct Erroneous Information

Practitioners have the right to correct erroneous information. Omissions, inconsistencies, or erroneous information discovered during the primary source verification processes will require further investigation to determine if one (1) or more of the following actions is needed:

- Submit to THP Medical Director for review
- Request additional information, in writing, from the practitioner. Corrections can be submitted to THP Provider Data Quality (PDQ) team at pdq@healthplan.org.

If written response is not received within fifteen (15) calendar days, a credentialing representative will contact the practitioner office via email or phone. If response is not received after the additional fifteen (15) days, the file will become inactive, and the practitioner will be notified by letter.

Once all required information is received, the practitioner will be notified via email, fax, or telephone. THP will document receipt of the corrected information in the practitioner's credentialing or recredentialing file. The information along with the practitioner's explanation will be taken to the medical director and/or blinded and presented to the PRC. The committee will determine the following actions: acceptance, acceptance with restrictions, or rejection.



Right to be Informed of Credentialing Status

Practitioners can, upon request, be informed of the status of their credentialing or recredentialing application. The information that will be afforded to the practitioner includes the following:

- Application in process
- Application pending to the PRC
- In review by THP's medical director

Practitioners may request their application status by contacting THP at 1.800.624.6961. A response will be provided via phone or e-mail with the application status within five (5) business days of request.

Standards for Participation

To join THP's provider network, a practitioner must meet the standards of participation as developed by THP.

A practitioner must have the following:

- Active Drug Enforcement Administration (DEA) certificate for each state(s) the practitioner practices if the scope of practice would warrant the practitioner to have a DEA
- Professional liability – minimum amount of \$1 million, any amount below minimum will be reviewed by the Professional Review Committee
- Privileges at a THP participating hospital
- Board-certification or board eligible. If not board-certified or board-eligible, the practitioner must demonstrate appropriate training for specialty listed
- Partially executed and dated THP practitioner agreement or evidence of the intent to join under a fully executed group provider agreement
- Office site visit, as applicable
- Active and current state medical license(s) for each state(s) the practitioner practices
- Sufficient information concerning any malpractice history
- NPI number
 - CMS made it their goal to increase the accuracy of provider directories and is requesting that practitioners review their demographic information in the National Plan and Provider Enumeration System (NPPES) registry and make necessary corrections to the data and attest to the accuracy
- Completed application with a current dated attestation
- Physician extenders practicing under a collaborative/supervising practitioner will be credentialed only if the collaborating/supervising practitioner is fully contracted and credentialed with THP.

THP Eligible Practitioners:

- Doctor of Medicine (MD)
- Doctor of Osteopathic Medicine (DO)
- Doctor of Podiatry (DPM)
- Doctor of Dental Surgery (DDS)
- Doctor of Chiropractic (DC)
- Audiologist (AUD)



- Certified nurse practitioner (CNP)
- Certified nurse midwife (CNM)
- Physician Assistant (PA)
- Independent physical therapist
- Optometrist (OD)
- Licensed psychologist
- Clinical licensed social worker (LICSW)
- Independent speech language pathologist
- Registered dietitian, diabetic educator, and nutritionist
- Licensed Professional Counselor (LPC)

THP Eligible Facilities:

- Ambulance
- Hearing Aid Dispenser
- Right From the Start (RFTS)
- Free Standing Imaging
- Ambulatory Surgery Centers (ASC) – must be accredited
- Dialysis Center
- Federally Qualified Health Centers (FQHC)*
- Rural health clinic (RHC)*
- Home Health (HH)
- Infusion Therapy– must be accredited
- Hospital – must be accredited
 - Critical Access Hospital (CAH)
 - Long Term Acute Care Hospital (LTAC)
- Outpatient physical therapy
- Skilled Nursing facilities (SNF)
- Behavioral health*– must be accredited
- Durable Medical Equipment (DME) – must be accredited and possess a surety bond; if applicable

*THP requires credentialing of all independently licensed practitioners including those practicing within a Licensed Behavioral Health Center (LBHC), Rural Health Clinic (RHC), and Federally Qualified Health Center (FQHC).

Ohio Ancillary Providers: Ancillary applications are located on the Ohio Department of Insurance's website. Practitioners unable to obtain these forms electronically should contact THP at 1.800.624.6961 to request email or certified mail delivery.

Agreements will not be executed by THP until the credentialing process has been completed and approved.

Notification of acceptance and/or rejection of credentialing will be sent within thirty (30) calendar days of the credentialing decision.

Mountain Health Trust (WV Medicaid and CHIP): In accordance with WV Code §9-5-34, upon receipt of an practitioner's clean and complete initial credentialing or recredentialing application, THP shall make a determination within sixty (60) calendars days. THP may request a one-time extension of up to thirty (30) calendar days deemed a substantive quality or safety concern in the course of credentialing/rec credentialing that requires further investigation. Extension justification must be submitted and approved by the WV Bureau for Medical Services, with notice issued to the practitioner that such extension is also warranted.



Practitioner Data Changes

Practitioners should submit data changes to THP no less than forty five (45) calendar days in advance. Mountain Health Trust (MHT) only: Practitioners should submit data changes to THP no less than thirty (30) calendar days in advance.

THP's provider portal resource library at myplan.healthplan.org, contains the forms needed to make updates to the following:

- Practice updates e.g., change of location or location closure
- Practitioner Demographic Change e.g., name change
- Practitioner Terminations
- Remittance (Pay to) Address

Submit completed form(s) to Provider Data Quality (PDQ) at pdq@healthplan.org.

Chapter 13

Compliance





Practitioner Reimbursement Compliance

Practitioners must inform members of costs of non-covered services prior to rendering the non-covered services. Practitioners may not balance bill or collect any payment from members for care that is determined to be not medically necessary.

Practitioners are prohibited from collecting copays for missed appointments. Members must be held harmless for the costs of covered services, except for any cost-sharing obligations.

Practitioners are required to treat all information obtained through the performance of services as confidential information to the extent that confidential treatment of such information is required under state and federal laws, rules, and regulations.

The Health Plan (THP) does not discriminate against practitioners acting within the scope of their license. Practitioners shall not face discrimination with respect to participation, reimbursement, or indemnification. Healthcare professionals, acting within their lawful scope of practice, are not prohibited or restricted from advising or advocating on behalf of a member with respect to their medical care or treatment options (including any alternative treatments); any information the member needs to decide among available treatment options; or the risks, benefits, and consequences of treatment or no treatment.

THP may not make payments, directly or indirectly, to a practitioner as an inducement to reduce or limit medically necessary services furnished to a member.

THP will provide information to members regarding their rights and responsibilities, including any changes, upon enrollment, annually, and at least thirty (30) calendar days prior to any change in benefits.

Participating and non-participating practitioner reimbursement is conditioned upon compliance with THP's benefit coverage determinations, medical necessity criteria, prior authorization requirements, coding rules, and reimbursement policies applicable to the member's benefit plan. A non-participating practitioner's acceptance of assignment of benefits does not create a practitioner participation agreement or confer any contractual rights beyond payment in accordance with applicable plan policies and state and federal regulations or laws.



Fraud, Waste and Abuse Regulations and Guidelines

Fraud, Waste, and Abuse (FWA) Policies and Related Laws

THP's FWA policies were established to prevent, detect, and correct fraudulent, wasteful, or abusive practices perpetrated by employees, members, and participating or non-participating practitioners. Compliance with these policies is the responsibility of anyone rendering services to THP members. Practitioners should ensure that all staff are thoroughly educated on state and federal requirements and that appropriate compliance programs are in place. THP expects its contracted practitioners to operate in accordance with all applicable federal and state laws, regulations, and program requirements, including Medicare Advantage, West Virginia Medicaid, and West Virginia Children's Health Insurance Program (WV CHIP). Pertinent laws include, but are 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 healthcare benefit program or to obtain by false or fraudulent pretenses, representations, or promises any of the money or property from a healthcare benefit program in connection with the delivery of, or payment for, health care benefits.

2. Federal False Claims Act (31 U.S.C. §§ 3729)

The Federal False Claims Act (FCA) prohibits any person from knowingly submitting false claims for payment, making a false record to get a claim paid, conspiring against the government to get a false claim paid, or making a record to conceal or avoid an obligation to pay the federal government.

3. Federal Criminal False Claims Statutes (18 U.S.C. §§287,1001)

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, imprisonment for up to five years, civil monetary penalties, and exclusion from participation in federal health care programs.

5. The Beneficiary Inducement Statute (42 U.S.C § 1128A(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 practitioner, or supplier, including a retail, mail order or specialty pharmacy.

6. Physician Self-Referral ("Stark") Statute (42 U.S.C § 1395nn)



Stark Law prohibits a physician from referring Medicare members 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 FCA. FERA makes it clear that the FCA imposes liability for the improper retention of Medicare or Medicaid overpayments. Consequently, a health care practitioner may violate the FCA if it conceals, improperly avoids, or decreases an "obligation" to pay money to the government.

8. Requirements for Reporting and Returning of Overpayments (42 CFR § 401.305)

Federal regulations require overpayments of federal funds for Medicare or Medicaid services to be reported and returned within 60 days of identification. The rule suspends the obligation to report the overpayment for up to 180 days if, after identifying a potential overpayment, the practitioner conducts a timely, good-faith investigation to determine whether an overpayment exists. Failure to report or return an overpayment within the specified period of time may trigger FCA liability. See [Chapter 3 – Claims](#) for additional information related to practitioner overpayments.

FWA Reporting

THP's Special Investigations Unit (SIU) and Compliance Department review all reports of suspected FWA and non-compliance. To report suspected FWA and/or suspected non-compliance, call the hotline at 1.877.296.7283. THP maintains a non-retaliation policy for anyone reporting issues in good faith meaning that no retaliation will be taken for reporting issues of concern. All issues may be reported anonymously.



Special Investigations Unit (SIU)

Medicare and Medicaid guidelines require THP to implement an effective program to prevent, detect, and correct FWA. THP values its relationship with practitioners and recognizes the importance of providing care to the community. THP is committed to promoting quality care for its members and proper payment to its practitioners for services rendered. Safeguarding payment integrity is an integral part of maintaining this mutually beneficial relationship. THP's SIU plays a vital role in detecting, preventing, and correcting FWA. The SIU does this by conducting investigations and recovering overpayments as required by state and federal regulations.

The SIU utilizes a skilled team capable of analyzing, auditing, and investigating claims and medical records. Practitioners may be contacted by the SIU as the result of routine post-payment monitoring or in response to a specific concern. Practitioners are expected to cooperate with the SIU and must promptly comply with requests for records or other information to promote timely completion of audits and reviews.

Medical records are reviewed by the SIU using national guidelines from various sources, which include the American Medical Association (AMA) and CMS. Practitioners are contractually required to provide medical records to THP upon request. Failure to submit requested medical records within the stated timeframe may impact the payment of future claims, the practitioner's network status, and/or result in the initiation of other legal remedies, as applicable.

See Chapter 4 – Medical Records for additional information related to medical records.

There are many tools that the SIU uses to promote payment integrity and to prevent and detect FWA. These tools include, but are not limited, to the following:

1. Post-Payment Reviews

In response to the receipt of a reported allegation of FWA or as a result of proactive datamining, the SIU may initiate post-payment review to determine if the reported allegation has merit. The post-pay review investigation may include a review of information from publicly available sources, member interviews or surveys, practitioner interviews, site visits, and/or medical record reviews. Practitioners may not receive advance notice that they are the subject of a post-payment review. Practitioners who receive a notice of review and/or a request for medical records may not receive the status of the review until its completion (subject to the requirements of the practitioner contract and/or applicable state and federal regulations).

Upon completion of a review, the SIU will notify the practitioner of any overpayments identified, providing educational resources, as applicable.



2. Practitioner Self-Audit

A practitioner self-audit is an audit, examination, or review performed by and within a practitioner's business. A self-audit may be performed proactively by practitioners as part of their own efforts to ensure payment integrity or at the direction of THP based on the discovery of questionable billing patterns. Self-audits are often preferred by practitioners because they review their own records, as opposed to SIU staff or government regulators. Self-audits are intended to be narrowly focused while still sufficient to address relevant issues. Self-audits are generally limited in scope and duration. Self-audits may be utilized for cases meeting the following criteria:

1. There are clear indications that overpayment has occurred;
2. The overpayment is likely to be systemic and/or extensive;
3. There are no previous or immediate indicators of intent to defraud; and
4. There is a high likelihood that the issue(s) can be resolved without significant SIU intervention

Practitioners are notified in writing when a self-audit is required. Self-audits are developed on a case-by-case basis, depending on the specific circumstances. However, in all instances the self-audit notification includes the purpose of the self-audit, parameters of claims to be reviewed including how the parameters were determined, deadline for audit completion, and instructions on how to remit any identified overpayments. Overpayments made under any federal health insurance program must be returned to the payer. Refer to **Chapter 3 - Claims** for timelines and processes related to overpayment recoveries.

3. Pre-Payment Review (PPR)

PPR is a process used to confirm that services are appropriately documented and billed prior to claims payment. PPR may be utilized when questionable or inappropriate billing patterns are identified or if a practitioner is suspected to be at risk of FWA, but where clear indices of fraud have not been identified. Practitioners may be referred to PPR by the West Virginia Bureau for Medical Services or by internal sources. Internal sources of PPR referrals include internal monitoring, post-payment review results, receipt of complaint(s), routine claims processing, and/or data mining.

Practitioners subject to PPR are notified in writing prior to the PPR effective date. The PPR notification includes relevant information regarding the reason(s) for the PPR, the date when a practitioner will be required to begin submitting documentation for claims adjudication, claim codes or types of claims subject to PPR, and the TIN(s) subject to PPR.

During the PPR period, practitioners are required to submit medical records and other documentation as applicable to support the services billed. PPR claims should be submitted with sufficient documentation to substantiate the nature, extent, and appropriateness of the billed services.

Failure of the practitioner to submit the required documentation or meet minimum documentation standards will result in claim denial.

Upon the conclusion of PPR, the practitioner is notified in writing that PPR has concluded, and any outstanding concerns and next steps.

THP reserves the right to conduct concurrent or subsequent post-payment reviews in response to any findings identified during PPR. THP also reserves the right to require a practitioner self-audit of previously



paid claims for compliance with applicable policies/rules/regulations. PPR is separate and distinct from other prior authorization and/or pre-adjudication requirements.

Corrective Action Plan (CAP)

Upon completion of a payment integrity activity, e.g., post-payment review, PPR, or self-audit, it may be appropriate to initiate a CAP. A CAP is required when a payment integrity activity reveals significant, complex, or material deficiencies. If a CAP is required, the practitioner is notified in writing of the issues subject to the CAP. The practitioner develops the CAP action items and submits it to THP for approval. Upon receipt and acceptance of the CAP by THP, the practitioner will be given a reasonable period of time to complete the corrections outlined within the CAP. Additional review or audit by THP may be conducted to assess the effectiveness of the CAP and to confirm the identified deficiencies have been adequately addressed.

SIU Overpayment Determinations/Demands for Repayment

Upon completion of a review, the SIU may determine that an overpayment has been made. The SIU will notify the practitioner in writing of the overpayment and make demand for repayment. This notification generally contains a list of affected claims along with the reason each claim line item was identified as an overpayment. Demands for repayment will abide by all applicable state and federal regulations and statutes.

SIU Overpayment Determination Appeals

The practitioner has 40 calendar days from the date of notification letter, or a period of time as required by state law, to file an appeal or dispute of the overpayment. The practitioner's written request must cite the reason(s) for disputing the overpayment determination (specific to the individual claims lines, where applicable) and should include applicable supporting documentation. The appeal will be reviewed by a secondary reviewer who did not participate in the initial overpayment determination.

If an appeal or dispute is not made within the appeal timeframe, the applicable recoupments will be made in accordance with **Chapter 3 - Claims** of this manual.

There are no appeal rights granted for overpayment determinations made as a result of a practitioner self-audit.



Practitioner Compliance Training

THP prepares the following education programs to encourage compliance. THP also issues practitioner communications to facilitate preventative actions and has a team of Practice Management Consultants (PMC) available for individualized education sessions. Visit THP's corporate website at healthplan.org or secure provider portal at myplan.healthplan.org for more information on these trainings.

1. Fraud Waste Abuse (FWA)

All practitioners and staff members who render health care services to Medicare Advantage members, provide Medicare Part C services, administer the Medicare Part D prescription drug benefit, or provide services to MHT members should complete FWA training. Practitioners should complete their own FWA training or use documents provided by THP. Practitioners are not required to send a training attestation to THP but must maintain evidence of training for at least ten (10) years. This documentation may be in the form of attestations, training logs, or other means sufficient to provide evidence of completion of these requirements.

2. Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) Model of Care (MOC)

Annual D-SNP MOC training is required for participating Medicare Advantage practitioners and out-of-network practitioners that render care to THP's D-SNP enrollees.

3. Cultural Competency, Implicit Bias, and Social Determinants of Health (SDoH)

To ensure that practitioners provide services in a culturally competent manner, THP developed cultural competency and social determinants of health (SDoH) practitioner education.

4. Motivational Interviewing

To ensure staff and practitioners establish a respectful stance with members, coworkers, and other stakeholders, practitioners should practice motivational interviewing techniques. Motivational interviewing allows practitioners to receive clear and objective feedback from members and other staff members.

Motivational interviewing elements include:

- Partnership – Helping people change
- Acceptance – Understanding a person's experiences and perspectives
- Compassion – Promoting a person's wellbeing and expressing empathy
- Plan – Organizing a plan based on a person's insights
- Engage – Listening carefully and acknowledging strengths



Compliance Through Reporting

THP 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 cannot mitigate or resolve the problem.

THP also believes that an issue involving potential or actual non-compliance or FWA can be best investigated and remediated if an individual 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, THP provides various reporting resources including a confidential FWA and compliance hotline at 1.877.296.7283, email at compliance@healthplan.org, SIU@healthplan.org, or on THP's corporate website at healthplan.org. These reporting mechanisms are available and widely publicized to all employees, practitioners, and contractors to report potential issues involving FWA and/or non-compliance.
- THP adopted and requires all practitioners 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 Advantage, WV Medicaid, WV CHIP, 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. THP and its contracted practitioners 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 practitioner must perform a check to confirm its employees and others that perform administrative or health care services for THP's Medicare Advantage and MHT 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 General Service Administration's System for Award Management (SAM) exclusion databases.

- Office of Inspector General (OIG) List of Excluded Individuals and Entities: [https://exclusions.oig.hhs.gov/General Services Administration](https://exclusions.oig.hhs.gov/General%20Services%20Administration) (GSA) System for Award Management (SAM): <https://sam.gov/content/exclusions>
- In the event anyone is found on either of these exclusion lists, they must be immediately removed from work related directly or indirectly to THP's Medicare Advantage and MHT programs. You must also notify THP of the finding.
- Practitioners must maintain a record of exclusion list reviews, e.g., logs or other records, to document that each employee has been checked through the exclusion databases in accordance with current laws, regulations, and CMS requirements.





HIPAA Privacy and Security

THP is committed to ensuring the confidentiality, integrity, and availability of its members' protected health information (PHI). PHI includes individually identifiable information that relates to an individual's past, present, or future health care or payment for health care, whether in written, spoken, or electronic form.

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that requires covered entities such as THP and healthcare practitioners to:

1. Properly secure PHI
2. Protect the privacy and security of member PHI
3. Abide by the "minimum necessary" standard for the use and disclosure of member PHI
4. Abide by individual rights such as the right of individuals to access their health information
5. Notify individuals and the Department of Health and Human Services in the event an individual's PHI is breached

HIPAA laws and regulations apply to health plans, practitioners, and health care clearinghouses as well as business associates who perform services on their behalf.

THP recommends that entities who work with PHI establish a privacy and security program for their individual organization including the execution of a training program that addresses HIPAA requirements. For more information about HIPAA, visit the Office for Civil Rights' website at <https://www.hhs.gov/hipaa/index.html>. More information related to THP's HIPAA policies and procedures can be found on THP's corporate website at healthplan.org → "HIPAA Notice of Privacy Practices" and "HIPAA Privacy Information and Forms."



Resources:

1. U.S. Department of Health and Human Services- Office for Civil Rights (OCR):
<https://www.hhs.gov/ocr/index.html>
2. HIPAA Frequently Asked Questions for Professionals (FAQs): hhs.gov/hipaa/for-professionals/faq
3. Health Care Compliance Association (HCCA):
hcca-info.org
4. 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
7. A Roadmap for New Physicians: Avoiding Medicare and Medicaid Fraud and Abuse: oig.hhs.gov/compliance/physician-education/index.asp
8. Compliance Guidance for Individual and Small Group Physician Practices oig.hhs.gov/authorities/docs/physician.pdf
9. General Compliance Program Guidance
<https://oig.hhs.gov/compliance/general-compliance-program-guidance/>
10. Health Insurance Portability and Accountability Act (HIPAA) hhs.gov/hipaa/for-professionals/index.html
11. Stark Law (Physician Self-Referral) cms.gov/Medicare/Fraud-and-abuse/physicianselfreferral/index