ProviderFocus
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REMINDER: Signatures, Credentials and Dates Are Important

Each entry in the patient's medical record requires the acceptable signature, including credentials and the date of the person writing the note.

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Contacting the Medical Director
Review Determinations

When review determinations are disputed or confusing for the attending physician, one available option is sometimes overlooked: A call to the medical director requesting clarification. It's a firm policy of The Health Plan that a medical director will always be available during business hours to discuss such rulings and the reasons behind them, Ordinarily, the conversation needs to take place between two physicians rather than be transmitted through third parties in either office. A determination may change with the addition of new information imparted during a conversation between the two physicians.

When physicians make such an inquiry, it is recommended to have the patient's name, referral number and/or ID number available to enable the medical director to access the electronic record at the outset of the call. It is not mandatory to have this information to initiate a discussion, but without a number to identify the ruling in question the medical director may have to call back after the patent's record has been identified in the system.

Claims and eligibility issues are usually more quickly handled by the Claims Department or the Customer Service Department, but we will help whenever we can.

You may reach the medical director at The Health Plan by calling 1.800.624.6961, ext. 7643 or 7644.

Accurate Contact Information is Important

Reviewing Your Information for Accuracy Helps Patients Reach You

The Centers for Medicare and Medicaid (CMS) has completed its first round of auditing the accuracy of online directories on plans who market Medicare Advantage plans. The type of inaccuracies cited among the plans included patients being unable to schedule an appointment at a listed practice location, incorrect phone numbers and suite numbers, and providers not accepting new patients.

THP is proactively auditing our online directories. Phone calls have been placed to a significant sample of practices throughout our service areas. In an ongoing effort to improve the accuracy of provider information listed within directories, CAQH ProView will ask providers to confirm that the phone number listed for each practice location is the primary method that patients should use when scheduling an appointment.

How To Prepare: On the review screen, the provider will be asked to confirm that the phone number entered in the office phone number field should be used by patients to schedule an appointment.

Impact: <1 minute per location entry

Why: Patients depend on the accuracy of provider directories when choosing a health plan and physicians. Inaccurate directories pose significant challenges for patients, contributing to delays in care, limiting choices of providers and masking problems with network adequacy.

Improved provider directories will:

- Display an accurate account of The Health Plan network
- Identify providers who are accepting new patients and their contracted insurance coverage
- List providers who meet the language and location needs of patients

We thank you for your cooperation with this process. Accurate directories protect consumers from inadvertently visiting out-of-network providers who could leave them with higher out-of-pocket expenses. To submit practice changes in writing, contact hpecs@healthplan.org.

Note: These changes will NOT affect a provider's status in CAQH ProView or the ability for authorized participating organizations to view an already current and complete data profile.

Member Rights and Responsibilities

We would like to remind all provider offices that the member rights and responsibilities can be found in the Provider Procedural Manual, Section 3. This manual is available on our website, healthplan.org. If you would like a copy please contact Provider Relations Customer Service at 1.800.624.6961, ext. 7901.

Compounded Pain Cream Scams

Fraud Alert

Please be alert to one of the most current and costly scams being conducted to date. Pharmacies that are marketing a variety of compounded creams place calls to members/patients offering the pain cream and inquiring if they may contact their physician to discuss it. The pharmacy will fax or send a pre-filled in form to the physician office requesting signature. The pharmacy then submits a claim for these creams, typically at a grossly inflated cost. In some instances they bill for thousands to tens of thousands of dollars for small quantities of the cream; if it is sent out to the patient at all. In many cases, these creams contain medications that in whole or part are not FDA approved or not approved for topical use. In other instances, the creams do not even contain the substances the pharmacy is billing for.

What You Can Do to Help:

Please be alert to these scams and be cautious of what you are signing. Be sure that these creams, supplies or various types of equipment are truly needed for your patients. Remember, by signing the form, you could be putting yourself at risk as well.

Make sure your patients know what YOU think they need in terms of supplies, equipment, and treatment. Often educated members are proving to be the front line for discovery of these scams.

REMINDER: CMS Annual Training Requirements

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

- **The training must be completed within 90 days of the initial hire or the effective date of contracting and at least annually thereafter.**
- **You are required to maintain evidence of training for a period of no less than 10 years; this may be in the form of attestations, training logs or other means determined by you to best represent completion of your obligations.**

To view the training module for FWA, or for additional Compliance and FWA resources, go to CMS MLN at: cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html.

Annual Review

2018 Practitioner Experience Surveys

The annual practitioner experience survey will be mailed out soon. The survey mailing will include behavioral health practitioners and secondary care physicians, along with all primary care physicians.

Please take the time to complete this survey so our Medical Management and Behavioral Health Departments can benefit from your opinion and suggestions to better serve you.

Your name will be on the survey tool as it has the past few years. It is our intent to be better able to follow-up on your complaints, concerns or issues when your name is on the form.

Any questions, please feel free to call the Medical Management Department at 1.800.624.6961, extension 7644 or 7643.

Caring for Medicare Members

Low Income Medicare Beneficiaries

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

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

The patient should make the provider aware of their QMB status by showing both their Medicare and Medicaid or QMB card each time they receive care. Patient should not get a bill for medical care that Medicare covers. Patient cannot be charged for Medicare deductibles, coinsurance and copayments.

Request for Services

Web-Based Precertification

For a more expedient review of requested services, please remember to attach your clinical information to the completed request prior to submitting the request to THP, or fax the clinical with the control number provided at the time of the web-based submission to the THP Clinical Services Department at 1.740.695.5297.

For providers utilizing the Cigna network, you cannot use the web-based portal for referrals. Those services must be called into THP Customer Service Department at 1.888.613.8385. A customer service representative will provide the eligibility and benefit information and warm transfer you to Cigna for completion of the preauthorization request.

Follow–Up After Hospitalization

Behavioral Health Admissions

It is very important that members receive follow-up care after discharge from inpatient behavioral health hospitalizations. The goal of timely follow-up care, within seven days of discharge, is to ensure continuous care, encourage wellness and prevent repeat hospitalizations.

Although there are may be barriers that practitioners do not have any control over, such as non-compliance with appointments, transportation issues or miscommunication between the in-patient facility and the member, scheduling of appointments in a timely manner is very important.

The Health Plan requests that practitioners:

- Communicate to hospital discharge planners that follow-up appointments should be scheduled within seven days of discharge
- Communicate to office staff that it is imperative to schedule appointments for patients discharging from the hospital within seven days of the hospital discharge
- Encourage member safety by facilitating and providing resources to promote treatment adherence
  - Educate the member on the importance of the follow-up visits
  - Contact the member if they fail to keep scheduled appointment
  - Identify vulnerable periods when a medication adjustment, or increase in phone calls or office visits may avoid decompensation and crisis

Communicating Information to Your Patients

New Medicare Card

Did you know that Medicare has materials available for you to help educate your patients on the new Medicare cards? Visit cms.gov/Medicare/New-Medicare-Card/Partners-and-Employers/Partners-and-employers.html for helpful information, including:

- One page Medicare and You flyer
- Job aids for partners, providing key messages to communicate to Medicare members
- Tear off pads for provider offices
- Small posters for provider offices

Learn more about the card chances by visiting: cms.gov/medicare/new-medicare-card/

Quality Improvement Accessibility

Creating a Positive Member Experience

The goal of the Quality Improvement Department is to improve medical outcomes and quality of service to our members. In order to identify issues, we routinely monitor inpatient and outpatient visits for any adverse events such as falls, post-op complications, unanticipated deaths and readmissions within 24 hours.

We also track PCP changes, which occur when a member chooses another physician to provide their care. Reasons often given for this change are after-hours accessibility issues, dissatisfaction with medical management, communication issues and issues related to the physician office staff.

If you or your patients have any questions or concerns about the care or service that they receive, we encourage you to call the Customer Service Department at 1.888.847.7902, or visit our website at healthplan.org.

The Health Plan's Commitment

Positive Provider Engagement

In an effort to better serve our providers and community, The Health Plan has recently restructured the Network Services division. As part of the restructure, a Provider Engagement Team will be responsible for servicing and educating both our providers and community members. The team will be more visible and accessible to our providers. As we continue to develop this program, new team members will be introduced in each region.

Valerie Ogilbee will be leading the team from the corporate offices in Wheeling, WV. Barbara Good has joined the team as the regional manager in the Charleston, WV region and Kayla Shreve will be the regional manager in Wheeling, WV. The team looks forward to developing partnerships with our providers and community as we strive to better serve our members.

Available Online

Clinical Practice Guidelines

The Health Plan and participating practitioners review and update the preventive health guidelines and clinical practice guidelines, which are available to you as a reference tool to encourage and assist in planning your patients' care.

To help make the information more accessible and convenient for you, we post the complete set of guidelines online. Just visit healthplan.org/providers/quality-measures to view standards, guidelines and program descriptions for Quality Improvement, Disease Management and Behavioral Health practice guidelines.

Improving Healthcare Costs and Quality

Provider Analytics Program

The Health Plan is pleased to announce continuation of its provider analytics program. The provider analytics program uses CCGroup Marketbasket System™ analytical software, which builds episodes of care from claims data and ties them to specialty-specific medical conditions commonly seen in clinical practice. The episodes are analyzed for trends related to cost, utilization and adherence to evidence-based quality measures in order to create peer-to-peer comparative provider scorecards.

The Health Plan's mission continues to include improving healthcare costs and quality. Transparency in sharing data is essential for transitioning to value-based reimbursement. Historical data is currently available to primary care providers on our secure provider portal. Summary reports, serving as a review of activity related to patient care and as a comparison using specialty-specific peer groups, have been updated to reflect 2015-2017 claims data.

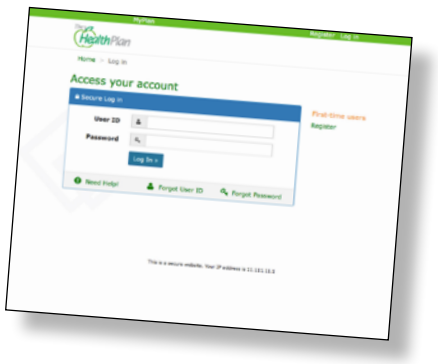
Further information regarding the provider analytics program may be obtained by contacting Brenda Cappellini, Director of Clinical Analytics and Technology Research (bcappellini@healthplan.org).

New Provider Portal

Information at Your Fingertips

We are pleased to announce our new secure provider website has launched. With this new site, we have integrated enhanced security features to keep your information better-protected. We've also improved the website's functionality to allow for a more efficient and user-friendly experience. We hope you enjoy these enhanced features. Please logon to our website to explore the many functions to help your practice:

- Patient search: ID cards, copays, deductibles
- Claims submit and status
- Pre-authorization submit and status
- Patient rosters
- Vouchers



Review of Your Practice Information

The Health Plan strives to provide the most updated information to our members regarding our network provider information such as physical location, telephone number, hospital affiliation, is the provider accepting new patients, and any other restrictions you may have. Confirmation of what lines of business your practice participates in is also vital. Follow these steps to verify your information:

1. **Log on to findadoc.healthplan.org.**
2. **Search by LAST NAME and ZIP CODE or STATE. Our system will show all practitioners with the same last name. Select the provider to view all of the current information available on our system. If you do not have access to the Internet, simply give us a call and we will gladly review the information relative to your practice. Large groups may call us to request a report of all providers linked by tax number.**
3. **Any changes should be reported in writing. Please fax changes to 740.699.6169 or email hpecs@healthplan.org.**

Note: This notice will be generated quarterly to satisfy CMS reg. §§ 422.111 and 422.112 along with the Ohio Department of Insurance.

REMINDER: Prior Authorizations

Before transferring patients from facility to facility, prior authorization is required.

Continuity and Coordination of Care

Behavioral Health Care and Primary Care Practitioners

Continuity and coordination of care between behavioral and physical health care providers is an important aspect in the delivery of quality health care as behavioral and medical conditions can interact to affect an individual's overall health.

No specific documentation is required for release of information to another practitioner for continuity of a patient's treatment. Written authorization from a patient is required before information related to substance abuse is released.

The Health Plan's continuity of care consultation sheet is an excellent form to use in sharing information and can be accessed through the provider web page.

An article that explores the topic of continuity and coordination more in depth is also located on the provider web page.

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