THP ProviderFocus
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Inside this issue …

The HealthPlan

Faster Payments
VPay for Self-Funded Groups

During the next few months, The Health Plan's Self-Funded employer groups will provide claim payments using virtual cards (VCards®), issued by our partner VPay through the Mastercard network in lieu of paper checks.

This enhancement, already used across the industry, is a faster, more efficient and safer method of payment. Payments and payment explanation are sent via fax and tracked on a real time basis.

The virtual card payment can be processed through your merchant terminal as a standard credit card transaction.

* There is no enrollment or further action required by you to receive these payments.

Benefits of VCards include:

- Faster payments – VCards are delivered via fax, so you will receive payments much faster than you would with mailed checks.
- Easier reconciliation – The EOP is delivered with the payment.
- No bank deposits – Once you process the payment, funds will be deposited directly into your merchant account.
- Protection against fraud – VCards eliminate the risk of fraud. Our partner VPay guarantees delivery of funds to your account. No more stolen, lost or whitewashed checks.

If you choose to opt out of this payment program, please call VPay Customer Service at 1.855.893.3027 after you receive the first payment (by virtual credit card). At that time, you can specify whether you wish to receive payments via check or via EFT.

For questions regarding the receipt of the payment, call VPAY Customer Service Center at 1.855.893.3027. Please have your client reference ID available.

Thank you for your cooperation and for being an integral part of our provider network.

LARC Billing Process

For Immediate Postpartum Insertion Facilities and Providers

In order to receive separate reimbursement for a long acting reversible contraceptive (LARC) intrauterine device (IUD) or subdermal implant provided immediately postpartum in an inpatient hospital setting, hospitals and providers must adhere to the following guidelines:

- An inpatient obstetrical delivery claim must exist for the recipient and must include a secondary ICD-10 diagnosis code from the Z30.017 or Z30.430 Comprehensive Management).
- A separate claim specific to the LARC must be submitted.
  - A LARC device which comes from inpatient pharmacy stock must be billed on the UB form using Bill Type 0111.
  - A LARC device which comes from out-patient pharmacy stock must be billed on the UB form with a Bill Type 0131 and 340B stock must be billed on the UB form with a Bill Type 0131 and the modifier UD.
- The date of service on the claim for the LARC device or implant must fall within the date span on the corresponding inpatient claim for the obstetrical delivery excluding the date of discharge.
- Practitioners may bill for the professional service associated with insertion of the LARC device with the appropriate CPT code on a separate CMS1500 claim with a place of service of "21".

INSERTION	
11981	Insertion, non-biodegradable drug delivery implant (DX: Z30.017)
58300	Insertion of intrauterine device (IUD) (DX: Z30.430)
DEVICE/IMPLANT	
J7296	J7296 - levonorgestrel-releasing intrauterine contraceptive system, (Kyleena), 19.5 Mg
J7297	Levonorgestrel-releasing intrauterine contraceptive system (Liletta), 52 Mg
J7298	Levonorgestrel-releasing intrauterine contraceptive system (Mirena), 52 Mg
J7300	Intrauterine copper contraceptive (Paragard)
J7301	Levonorgestrel-releasing intrauterine contraceptive system (Skyla), 13.5 Mg
J7307	Etongestrel (contraceptive) implant system, including implant and supplies (Nexplanon)

Please remember that codes are subject to changes and updates

Intro to The Health Plan Webinar

Lunch and Learn

Join The Health Plan on Wednesday, August 22, 2018 from Noon to 1:00 PM EST to become acquainted (or re-acquainted) with The Health Plan. Topics discussed will include: The Health Plan lines of business, pre-authorizations, appeals, electronic data information, the provider portal, billing guidelines and claim resubmission guidelines. A certificate of attendance will be issued and may qualify for continuing education credit. Please register for The Health Plan Lunch and Learn Intro to The Health Plan at: https://attendee.gotowebinar.com/register/3813886270777657602.

Prior Authorization Requirement & Coverage Guideline

Clinical Drug Testing

Effective July 1, 2018, based on The American Society of Addiction Medicine's (ASAM) published consensus statement, The Health Plan updated the guideline related to review of clinical drug testing for addiction treatment programs and pain management programs for all lines of business.

https://www.asam.org/resources/guidelines-and-consensus-documents/npg

WV Medicaid:

- The Health Plan will be following the benefit limits established by BMS
- Members are eligible for up to 24 presumptive drug screens (80305 – 80307) per year.
- The code limit for definitive drug screens (G0480, G0481, and G0482) is now 12 in combination per calendar year. Medical Necessity Authorization is required beyond service limits.
- Code G0483- definitive drug testing for 22 or more drug classes - now requires medical necessity authorization from the INITIAL service prior to payment.
- Code G0659- definitive drug testing to identify drugs that do not have a specific test available - now requires medical necessity authorization from the INITIAL service prior to payment.
- To exceed the benefit limit, providers must contact The Health Plan to obtain a medical necessity authorization.

Providers may find detailed policy on BMS's website: https://dhhr.wv.gov/bms/Pages/Chapter-529-Laboratory-Services.aspx

All other lines of business (Fully Funded Commercial, TPA and Medicare):

- The Health Plan will refer to coverage established under Local Coverage Determinations (LCD) related to the appropriate service area unless or until a National Coverage Determination (NCD) is issued by CMS.
- Members are eligible for up to 24 presumptive drug screens (80305 - 80307) per year.
- Members are eligible for up to 12 definitive drug tests (G0480) per year
- Definitive drug tests requested for codes G0481 - G0483 and G0659 will require prior authorization for medical necessity for all testing.
- To exceed the specified limit above, providers must contact The Health Plan to obtain a medical necessity authorization.

Providers may find detailed policy on CMS's website: www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx

Please remember to use participating labs with The Health Plan.

REMINDER: Compliance & FWA Training

Compliance and FWA training should be completed on an annual basis. Training may be completed through your own internal compliance program or by using training documents provided by The Health Plan.

Training should be completed within 90 days of the initial hire date or the effective date of contracting and at least annually thereafter.

You are required to maintain evidence of training for 10 years. This may be in the form of attestations, training logs or other means.

REMINDER: Prior Authorizations

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

Communication is Important

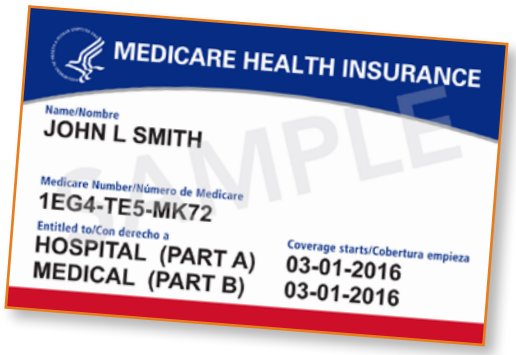
PCP Member Rosters

The Health Plan receives frequent calls when primary care physicians (PCPs) receive referrals for members who have selected them as their PCP, but the office has never seen the patient. This may occur when a member must choose a PCP at the time of enrollment and they are not established with a PCP. Medicaid members may be auto-assigned to a PCP when the member hasn't chosen a PCP. This is an opportunity to grow your practice!

The Health Plan encourages you to contact the member and schedule an appointment to get acquainted. If the office cannot accommodate the member as a patient please send a letter of explanation to The Health Plan, Attention: Customer Service, 1110 Main Street, Wheeling WV to have the member removed from your roster. Member rosters are updated daily and are available on The Health Plan's provider portal for viewing at healthplan.org/providers.

New Medicare Card

New Medicare Cards Have Been Mailed in WV

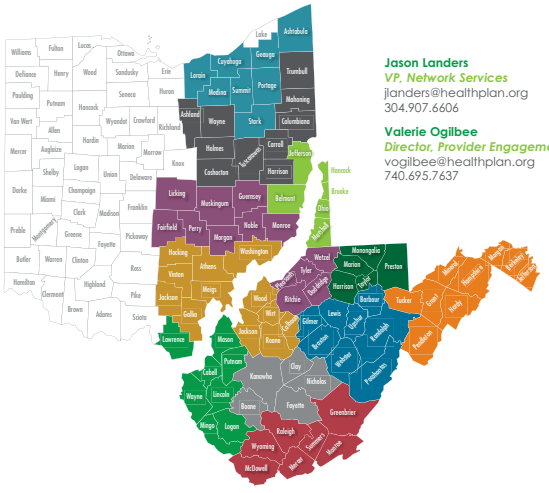


The new Medicare cards will have a unique number assigned to Medicare beneficiaries instead of a Social Security Number. This will help to protect identity. Medicare has materials available to help educate your patients on their new Medicare cards. Visit https://www.cms.gov/Medicare/New-Medicare-Card/Partners-and-Employers/Partners-and-employers.html for helpful information.

Provider Engagement

Update

The Health Plan continues to grow the recently restructured Provider Engagement Team. Our team is currently working on introducing themselves within each community they serve. We have updated the territory map, which is included in this newsletter. Feel free to reach out to your newly appointed representative!



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* Denotes open positions currently covered by managers.

Updates

Preauth Guidelines

The Medical and Behavioral Health Preauthorization guidelines have been updated effective July 1, 2018. To view and print the newly revised guidelines please visit: healthplan.org/preauth.

Behavioral Health Admissions

Follow-up After Hospitalization

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 may be barriers that practitioners do not have any control over, such as non-compliance with appointments, transportation issues or miscommunication between the inpatient 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 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.

Forwarding Order Expiring

Correspondence and Claims Address

Please be advised that The Health Plan's postal forwarding order will expire November 1, 2018 and all claims and correspondence mailed to The Health Plan's former address in St. Clairsville, Ohio will be returned to you. Ensure that your billing staff, billing service and clearinghouse are mailing all correspondence and claims to The Health Plan, 1110 Main Street, Wheeling, WV 26003 to avoid delays in processing and payment.

Attention! Edifecs Transition In Progress

Electronic Claims

We are pleased to announce we have begun to transition our current electronic claims review process to Edifecs Transaction Manager. The new technology provided by Edifecs, Inc. ("Edifecs") will allow for increased functionality, including enforcing quality claim submission.

Edifecs is considered the industry's gold standard for electronic claim transaction management. The Edifecs Transaction Manager is used by the Centers for Medicare & Medicaid Services and the Council for Affordable Quality Healthcare. We will manage and fully support the Edifecs Transaction Manager, which will assist in a seamless transition and ensure you continue to work with our staff for your customer service needs.

Please share this important information with your office manager, billing staff and/or billing vendor. If you have questions OR If you have not been scheduled for transition and would like to do so immediately, please email hpecs@healthplan.org.

Home Health

Clarification of Start of Care Requirement

Effective March 1, 2018 The Health Plan amended the pre-authorization requirements for home health services. Pre-authorization is required only if services extend past the first certification period (the first 60 days of care).

To avoid claim denials, The Health Plan requires the start of care date and the current certification period on each claim submitted (Box 80 on the UB04 paper claim and in the free text box for an electronic claim). It is NOT necessary to submit Form 485.

Please submit all paper claims to:

The Health Plan
1110 Main Street
Wheeling, WV 26003.

To pre-authorize services for Fully Insured members, including Commercial plans (HMO, PPO, POS), call 1.888.847.7902.

To pre-authorize services for Medicare members, call 1.877.847.7907.

To pre-authorize services for Medicaid members, call 1.888.613.8385.

To pre-authorize services for Self-Funded members, call 1.888.816.3096.

Please share this with applicable staff. Thank you in advance for your cooperation.

Fall 2018 Molina Medicaid Workshops

Medicaid

The bi-annual Molina Medicaid Workshops will be held in September in eight cities throughout West Virginia for your convenience. In addition to Molina, the following agencies will be in attendance and presenting updates: The Bureau for Medical Services (BMS), Public Employees Insurance Agency, Skygen (formerly Scion Dental) and the four managed care agencies including The Health Plan.

Be on the lookout soon for a registration link with additional details on The Health Plan's website: healthplan.org.

2018 Molina Medicaid Workshop Dates and Locations	
September 10	Waterfront Hotel, Morgantown
September 11	Holiday Inn, Martinsburg
September 13	Oglebay Resort/Pine Room, Wheeling
September 14	Grand Pointe Conference Center, Vienna
September 17	St. Mary's Conference Center, Huntington
September 18	Tamarack, Beckley
September 19	Holiday Inn & Suites, South Charleston
September 20	Days Inn, Flatwoods

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.

Medical Management

Behavioral Health Review Criteria

Nationally recognized clinical criteria is utilized to perform reviews for medical appropriateness. This allows for consideration of the needs of the individual members, their circumstances, medical history, and availability of care and services within The Heath Plan network. Annually, or as needed, input is sought in the review of criteria from physicians participating in the Physician Advisory Committee.

The Health Plan utilizes McKesson InterQual® criteria as a screening guideline to assist the nurse reviewers with respect to medical appropriateness of health care services, including behavioral health criteria used in an active clinical review process of a procedure requiring the use of InterQual®.

InterQual® may be utilized to assist in the review of admissions, as well as surgical and radiological procedures including, but not limited to, MRI, MRA, CT scan, hysterectomy, ECT and psychological testing.

You may call The Health Plan Medical Department at 740.695.7643 or 1.800.624.6961, ext. 7643 or 7644, or Behavioral Health Services at ext. 7896, if you have a general InterQual® question or a question regarding a particular case. InterQual® review worksheets are available upon request.

Please indicate if your request is emergent so that we may expedite the review.

Simply scheduling the testing/procedure does not warrant an expedited review.

Unless an emergency, scheduling should be done after being approved by The Health Plan.

Medicare Advantage

CPT Code 99397

CPT code 99397 (Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 65 years and older) is not reimbursable for The Health Plan Medicare Advantage population. As a reminder, advance beneficiary notice of noncoverage (ABN) forms may not be used for Medicare Advantage members to collect payment for noncovered services from the member.

Very Important to Keep Your Information Current

In this electronic age of direct deposit, electronic remittance advices and electronic submission of claims we may lose sight of remembering to notify The Health Plan of any changes. It is important to notify us of any changes, such as a change in your physical location, telephone number, back up coverage, hospital affiliation and practice restrictions. All of this information is gathered in order to provide the most current information to our members in the form of directories, whether they are electronic or paper.

To ensure you are correctly listed in our directories, please take a minute to check the information on our website, healthplan.org and select the Find a Provider link. Search using only your last name. Once you find your name on the list, double-click to review your full practice information.

Psychotherapy Reminder

Reminder to Behavioral Health Providers that The Health Plan no longer requires preauthorization for psychotherapy visits. This pertains to all lines of business, however, certain ASO (self-funded) groups may continue to require preauthorization. Contact The Health Plan's Behavioral Health Unit at 1.877.221.9295 to clarify any questions that you may have.

Affirmative Statement

Regarding Incentives August 2018

The Health Plan bases its decision making for coverage of healthcare services on medical appropriateness utilizing nationally recognized criteria. Incentives are not offered to providers or employees of The Health Plan involved in the review process for issuing non-authorization nor does The Health Plan specifically reward, hire, promote, or terminate practitioners or other individuals for issuing denials of coverage. Also, no incentives are given that foster inappropriate under-utilization by the provider, nor does The Health Plan condone under-utilization, nor inappropriate restrictions of healthcare services.

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.

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.

Provider Practitioner Manual

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

The Health Plan

1110 Main Street
Wheeling, WV 26003-2704

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