ProviderFocus

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Provider Manual

The Provider Manual can be accessed on The Health Plan's public website at healthplan.org/providers/resources/provider-manual.

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Talk to Patients about Advance Directives

Patients prepare advance directives in an effort to maintain autonomy during periods of incapacity or at the end of life. Advance directive documents are specific to the state in which the patient lives, but an effective strategy in the family physician's office involves more than filling out a form. Primary care settings offer opportunities to engage patients in discussions about advance directives as part of a wellness office visit. If the patient has already completed a living will and/or a durable healthcare power of attorney, ask that they provide a copy for the office to keep on file. If they have not previously completed advance directive documents, ask if they would like information.

Members can call The Health Plan at 1.800.624.6961, ext. 7504 or access The Health Plan's website at healthplan.org. It is important to include in your office documentation any discussions that occurred, information that was provided, or the patient's refusal to talk about the subject. If members have previously asked for advance directive information, or refused, it is important to routinely continue to have follow up discussions to identify any changes in their decisions.

MTM Program

Medication Therapy Management (MTM)

The Health Plan and Enhanced Medication Services (EMS) have continued their partnership and the medication therapy management (MTM) program this year. EMS offers interactive telephonic medication reviews to our qualified Medicare members. Those who qualify will be contacted by a pharmacist to complete a comprehensive medication review (CMR) once a year and their progress will be assessed quarterly. By performing these reviews, we aim to improve patient outcomes and address possible adverse events as well as polypharmacy, overutilization, and suboptimal dosing.

As a part of the healthcare team, you may receive calls or faxes from Enhanced Medication Services (EMS) to address issues that have been identified during our medication reviews. For example, you may receive a call or fax about a drug-drug interaction, an adverse event, or non-adherence. EMS may also call you to complete the CMR for a cognitively impaired patient. As an advocate for the patient's health, we encourage you to complete this process with EMS to determine if any changes to therapy would be beneficial and to ensure patient safety. By working with you, we aim to bridge the healthcare gap and improve patient care. We hope you will take advantage of this opportunity and thank you for your dedication.

Delivering the Most Value to Our Members

THP's Specialty Pharmacies

As part of The Health Plan's ongoing commitment to high quality treatment and focus on keeping healthcare affordable, The Health Plan Pharmacy Department completes an annual review of the specialty pharmacy network. This review ensures that The Health Plan is delivering the most value to our members. The specialty pharmacies in our network have demonstrated best-in-care practices and will help you get the most from your specialty medication. The Health Plan has selected the following pharmacies to participate in our specialty pharmacy network: AcariaHealth, Accredo HealthGroup, Inc., Allied Health Solutions, Amber Specialty Pharmacy and Kroger Specialty Pharmacy.

Upon approval of a specialty drug, The Health Plan will notify you and your patient of the preferred specialty pharmacy for the requested specialty drug. Below is the contact information for each pharmacy in The Health Plan's network:

	Phone	**Fax**
AcariaHealth	1.800.511.5144	1.877.541.1503
Accredo HealthGroup, Inc.	1.800.803.2523	1.800.391.9707
Allied Health Solutions	1.304.285.7216	1.304.598.4034
Amber Specialty Pharmacy	1.888.370.1724	1.402.896.3774
Kroger Specialty Pharmacy	1.855.802.3230 or 1.855.733.3126	1.888.315.3270

CMS Annual Training

Reminder

Compliance and Fraud, Waste and Abuse (FWA) training should be completed on an annual basis. You and your employees should complete Compliance/FWA training through your own internal compliance program or by using training documents provided by The Health Plan, which are available at myplan.healthplan.org.

You and your employees should complete Compliance/FWA training within 90 days of hire and at least annually thereafter. As a contracted provider, you are required to maintain evidence of Compliance/FWA training, such as training logs or other records, for at least 10 years. You must be able to produce evidence of Compliance/FWA training upon request.

REMINDER: Signatures, Credentials and Dates Are Important

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

Hours of Operation Reminder to Providers

The Health Plan ensures that practitioners offer hours of operation that are no less (in number or scope) than the hours of operation offered to non-Medicaid or non-Medicare members.

Encourage Your Patients to Obtain the COVID-19 Vaccine

Medicaid and WVCHIP members that have completed their COVID vaccination process will receive a $25 gift card as part of the THP healthy initiative program. Cards will be mailed out starting in July and will be provided to members that have already received a vaccine back to January 1, 2021, as well as all future members that receive a vaccination.

Residential Providers

Behavioral Health and Substance Use Disorder (SUD)

The Health Plan is pleased to announce a partnership with DisposeRx, to provide a tool to safely and securely dispose of expired or terminated medications. DisposeRx was designed to help reduce the occurrence and/or severity of certain risks associated with keeping unused medication around the home.

Possible adverse consequences of keeping these expired/unused medications in the home may include:

- Accidental ingestions/ poisonings
- Drug diversion and misuse/ abuse
- Medication confusion – which especially effects our senior population
- Overdoses
- Suicides
- Antibiotic resistance

The DisposeRx powder is non-toxic and non-hazardous. Each of the components is on the FDA's Inactive Ingredient List for approved oral medications. The technology includes crosslinking polymers that activate in water in the presence of unused medication in the original prescription vial in less than 30 seconds.

The Health Plan is providing these small DisposeRx packets free of charge to providers, so you may offer them to members who are discharging from Substance Use Disorder residential and other behavioral health programs for free. We are particularly interested in identifying members who are discharging to a location that is not managed and may contain the outdated medications of family members or friends.

THP would appreciate your assistance in this vital program. You are not required to identify the discharging member by MCO. All West Virginia citizens are welcome to take home one of these helpful medication disposal packets. More information is available, including a helpful video that explains how the disposal process works, at disposerx.com.

If you would like to participate in this program or have questions regarding the program, please contact Christy Donohue at cdonohue@healthplan.org or Jeff Wiseman at jwiseman@healthplan.org.

Radiology Prior Authorizations

eviCore Process Improvement

The Health Plan is happy to announce that our eviCore partners have implemented a new process enhancement that simplifies the radiology prior authorization experience for providers.

This new process minimizes the burden of follow up for the ordering provider's office staff by streamlining the survey questions and requesting that the medical record be uploaded for cases that are unable to be approved in real time. This allows a clinical reviewer to obtain any necessary clinical data up front, rather than require additional back and forth communication with the office staff. This enhancement will improve both staff efficiencies and case turn around.

Keep Provider/Practice Info Updated

Help Us, Help Patients to Find You

It is very important to remember to contact The Health Plan with any changes to your office location, telephone number, back up physicians and hospital affiliations. All of this information is gathered in order to provide the most current information to members of The Health Plan in the form of directories, whether they are electronic or paper.

The Health Plan has instituted a feature on our website to assist providers in verifying and updating information. It is located on the Find a Doc tool on THP's website at healthplan.org. Search by provider's name and view the provider details on file. Click the "Verify/Update Practice Info" button to submit corrected information or verify that the listed information is current and correct.

Caution is Key

Beware of Telemarketing Schemes

The most common reasons why your Medicare members often fall prey to telemarking schemes are:

- They are more trusting of strangers
- They may not be able to decipher if a phone call is real or a scam
- They are more likely to be home alone with little or no family members to assist them in determining if the call is a scam

According to CMS, several topical drugs have been targets of Fraud, Waste and Abuse through telemarking schemes. Medicare beneficiaries have received unsolicited phone calls inquiring if they had pain issues and inquire if they can contact their doctor.

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 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.

Another identified telemarking scheme was for the use of antibiotics and antifungals in footbaths, nasal rinse, and mouthwash preparations to prevent disease.

What Can You Do to Help?

Please be alert to these scams and be cautious of what you are signing. Be sure that these creams, supplies or other 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 on the front line for discovery of these scams.

How to Protect Your Patient from Phone Scams

Remind them:

- Never give their personal health information to someone they don't know
- Never give their Social Security, Medicare, or health plan numbers over the phone to someone they don't know
- Never provide banking information over the phone

Enroll Today

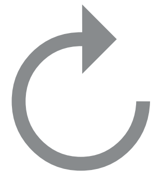
Gold Star Program

Providers are reminded that as of July 1, 2020, they have the opportunity to participate in The Health Plan Gold Star Program, which allows for any practitioner that has rendered a service at least 30 times per rolling calendar year and achieved a 100% approval rating within the past 6 months, to have subsequent authorizations requirements waived for that specific service code.

Providers may download the Gold Star Program application request in the The Health Plan (THP) provider portal and fax it to 1.888.329.8471.

Paper and Electronic Claims

Resubmission of a Denied Claim



You may resubmit a claim either on paper or electronically through your clearinghouse. When resubmitting a claim on paper, please include the following:

- A completed new CMS 1500 form
- Attach a copy of the payment voucher with the member circled or underlined that you are resubmitting a claim for
- A clear explanation and/or additional documentation as to why the claim is being re-submitted
- Indicate on the claim form "corrected claim" or "resubmitted claim"

Mail corrected paper claims to: The Health Plan, 1110 Main Street, Wheeling, WV 26003

To resubmit a claim electronically through a clearinghouse:

- Use Reason code "6" in claim information 2300 Loop Segment CLM05 to indicate a corrected claim
- Use "7" in claim information 2300 Loop Segment CLM05 to indicate a replacement claim.
- If you wish to void a claim, use "8" in claim information 2300 Loop Segment CLM05
- Please Indicate the original claim number in the free text field

Failure to follow the resubmission guidelines could result in a claim being denied as a duplicate

If you have questions, please contact customer service at 1.888.847.7902 for assistance on why a claim denied and how to resubmit your claim.

Affirmative Statement

Regarding Incentives

The Health Plan bases coverage decisions for medically-appropriate health care services by utilizing nationally-recognized criteria. Providers and employees of The Health Plan who are involved in the review processes are not offered incentives for issuing non-authorizations. Furthermore, The Health Plan does not offer incentives that foster inappropriate underutilization by providers. The Health Plan does not condone underutilization or inappropriate restrictions of health care services.

Clinical Practice Guidelines

Available Online

The Health Plan and participating practitioners routinely review and update the preventive health guidelines and the clinical practice guidelines. These are available to providers as a reference tool to encourage and assist in planning patients' care. To make the information more accessible and convenient for providers, THP has posted the complete set of guidelines online.

Visit healthplan.org/providers/patient-care-programs/quality-measures to view standards, guidelines and program descriptions for quality improvement, disease management and behavioral health practice guidelines.

Low-Income

Medicare Beneficiaries

The QMB (Qualified Medicare Beneficiary) 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 primary care physician (PCP), THP has coded your patient rosters with a symbol to help you identify which of your patients meet this income level. Patient rosters are available on our secure provider portal located at myplan.healthplan.org.

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

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

1.800.MEDICARE (1.800.633.4227).

Behavioral Health Credentialing – WVCHIP

WVCHIP requires Behavioral Health providers to be credentialed at the individual level as well as the Comprehensive/LBHC.

Superior Vision Now Partnered with THP

Effective July 1, 2021, Versant Health/Superior Vision will become the new vision partner of The Health Plan for our Commercial lines of business. There is no change to our Medicare, Mountain Health Trust or ASO products.

Facility Transfers Require Prior Authorization

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

Member Rights and Responsibilities

The Provider Manual describes the member rights and responsibilities in Sections 3 and 5. This manual is available on THP's corporate website, healthplan.org. To obtain a copy please contact Customer Service Department at 1.800.624.6961.

Quality Measures and Billing Guidelines

Identifying Gaps In Care

The Health Plan gathers, and reports performance rates based on quality of care, access to care, and the member experience with The Health Plan and our doctors. The Healthcare Effectiveness Data and Information Set (HEDIS) was developed by the National Committee for Quality Assurance (NCQA) and has become one of the most widely used sets of performance measures in managed care. Annual HEDIS/quality reporting is a requirement of health plans by NCQA and the Centers for Medicare and Medicaid Services (CMS) for use in health plan accreditation, Star Ratings, and regulatory compliance.

The Health Plan has developed reports that can assist you in identifying the services that your patients are missing, namely gap-in-care reports. Your practice management consultant will provide these reports upon request. Additionally, the billing and coding guidance for capturing these services is available on our website. For more details, visit healthplan.org/providers/patient-care-programs/population-health or contact your practice management consultant.

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