ProviderFocus

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Provider Practitioner Manual

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

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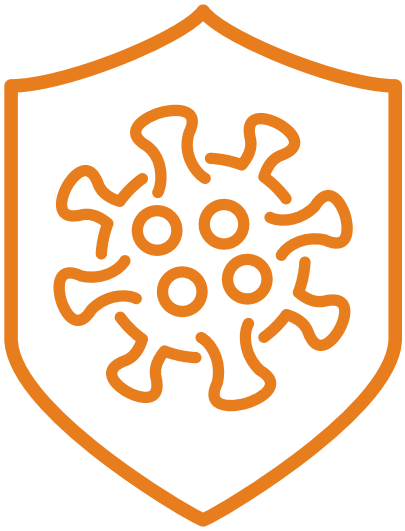
The Health Plan

THP Following CMS and BMS Guidelines Surrounding COVID-19



The Health Plan continues to follow the temporary measures related to healthcare services instituted by the Centers for Medicare and Medicaid Services (CMS) and the Bureau for Medical Services (BMS) during the coronavirus (COVID-19) pandemic.

Please refer to CMS' guidelines related to COVID-19 for THP members with Medicare and Commercial (including POS, PPO, HMO, WV PEIA) coverage. Those guidelines may be accessed at cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page.

BMS guidelines related to COVID-19 will be followed by THP for Medicaid members. Please visit the "News and Announcements" section of BMS' website at dhhr.wv.gov/bms/Pages/Coronavirus-Disease-2019-(COVID-19)-Alerts-and-Updates.aspx to access the latest information related to COVID-19.

Self-funded plans default to the group plan document.

These are temporary measures due to the COVID-19 crisis and The Health Plan will re-evaluate at a later date.

Contact The Health Plan at 1.800.624.6961 if you have any questions or need further assistance.

COVID-19 Fraud Impacts All of Us

Be Alert For Opportunistic Scams

Scammers never let a crisis go to waste. While we celebrate the healthcare heroes fighting on the front lines of the pandemic, we are also vigilant to guard against unscrupulous providers who would take advantage of this current environment. Bad actors may fraudulently bill healthcare payers for services not rendered to existing patients or non-existent services to ghost patients. Although THP's Special Investigations Unit suspended some of its routine activities to comport with social distancing guidelines and to avoid placing an undue burden on providers during the height of the pandemic, investigators are now resuming regular activities, effective June 1, 2020. As business operations return to normal, undoubtedly government regulators will be undertaking analyses to identify areas where fraud and abuse likely occurred, related to the COVID-19 crisis. The Health Plan's Special Investigations Unit will be conducting similar analyses and reviews.

The overwhelming majority of healthcare providers have high integrity, and many providers across the country have risked their own health to provide necessary care to their patients. Unfortunately, history suggests that bad actors will always find a way to exploit a vulnerable situation. Fraud impacts all of us: patients, payers, and providers. Patients may be denied legitimate services if limited benefits have been exhausted, or may incur out-of-pocket costs when claims are denied. Payers may respond to fraud schemes and losses by implementing more regulations or stronger oversight of providers, and increasing premiums. If one of your patients has been targeted by a scammer offering bogus tests, "COVID Kits," phony vaccines, or other scams, please contact THP's fraud tip line at 1.877.296.7283 or email SIU@healthplan.org.

Member Rights and Responsibilities

The Health Plan reminds all provider offices that member rights and responsibilities may be found in the Provider Practitioner Manual in Sections 3 and 5. This manual is available on THP's corporate website, healthplan.org. To obtain a copy please contact Provider Relations Customer Service at 1.800.624.6961, ext. 7901.

WV Medicaid Prior Authorization Requirements Resumed June 1, 2020

Following the Bureau for Medical Services' (BMS) guidelines, The Health Plan discontinued the temporary waiver of prior authorization, due to the COVID-19 pandemic, on May 31, 2020 for WV Medicaid members.

The need to authorize services that typically require prior authorization resumed June 1, 2020.

THP's prior authorization lists may be found on the provider portal at: myplan.healthplan.org, "Pre-Authorizations," "Pre-Authorization Lists."

Please direct any questions regarding prior authorization of services to the Medicaid Customer Service Department at 1.888.613.8385.

THP Affirmative Statement

Regarding Incentives - 2020

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.

Requires Prior Authorization

Cologuard Testing

Cologuard testing is not a covered benefit under the Affordable Care Act. Physicians writing orders for their patients for Cologuard testing must prior authorize the test through The Health Plan and the member must meet InterQual criteria. Cologuard testing will be denied if prior authorization is not obtained or if testing does not meet InterQual criteria. Please contact The Health Plan's Customer Service Department at 1.800.624.6961 to prior authorize services.

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.

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.

D-SNP Required Annual Training

The Centers for Medicare and Medicaid Services (CMS) requires annual training of providers that provide services to members of THP's dual-eligible special needs population (D-SNP).

THP's provider engagement reps will contact those providers providing services to five or more D-SNP members in a calendar year to complete training and attest to the training.

Training materials are available on The Health Plan's secure provider website, myplan.healthplan.org, under "Resource Library," "Training and Education."

Changes at THP

Jason Landers has a New Role

Jason is now senior vice president of Medicaid. He will lead THP's Medicaid team which provides care to approximately 100,000 WV Medicaid recipients. He has over 24 year's experience working in a variety of roles in healthcare such as managed care, physician recruitment and relations, and business development and practice administration.

Jason has a M.B.A. from West Virginia University and a B.S. in business management from WV Institute of Technology.

Announcing Two New Staff Appointments

Ed Kairis, MD, MMM Chief Medical Officer

The Health Plan is pleased to announce the appointment of Ed Kairis, MD, MMM as its chief medical officer. Dr. Kairis will provide leadership and direction to our medical directors and clinical operations. Dr. Kairis brings 15 years of managed healthcare experience to The Health Plan.

Dr. Kairis earned his Doctor of Medicine from the University of Pittsburgh School of Medicine and his Master of Science in medical management from Carnegie Mellon University. He is board-certified in pediatrics and holds an unrestricted license in Ohio and Pennsylvania.

Antoinette Geyer, Sr. VP of Provider Delivery Services

The Health Plan announces the appointment of Antoinette Geyer as its senior vice president of Provider Delivery Services. Geyer will provide leadership and direction to our NCQA accredited credentialing and enrollment teams as well as our provider contracting and provider outreach areas.

Geyer brings over 20 years of experience working in healthcare and network development to The Health Plan.

Geyer earned her M.B.A., cum laude with a focus on finance from Duquesne University and a B.A. in business and communications from the University of Pittsburgh.

Electronic Remittance

Change in Date

The Health Plan has made a change internally that **may** affect when an 835 electronic remittance advice will be received by providers.

Beginning with the July 13, 2020 check run, the 835 electronic remittance advice that previously accompanied payment **may not** be received until 24 to 72 hours after payment is issued.

Payment vouchers on THP's provider portal will be updated when the electronic remittance advice is released.

This change **will not** affect current THP payment schedules. You will continue to receive payment on the regularly scheduled date that you have in the past.

If you have not received your electronic remittance advice within 72 hours of payment receipt, please contact Customer Service at 1.877.847.7901 for assistance.

NaviNet Partnership

The Health Plan is excited to announce its partnership with NantHealth | NaviNet. NaviNet transforms provider-health plan communications by supplying real-time administrative and clinical information to improve care delivery and provider office workflows, enabling you to spend more time with your patients.

Currently, providers may access eligibility and benefits for THP members on NaviNet. You may access patient coverage and view, print and save member ID cards. The Health Plan will be expanding the types of services offered through NaviNet in the future.

If your office is new to NaviNet you may register online at connect.navinet.net/enroll. You will receive a welcome email containing training resources that will help you get started.

If you are already a NaviNet customer The Health Plan will automatically be added to your health plan menu. For assistance in receiving access, please click on the Contact Support button at the top of the NaviNet page after logging in to support.nanthealth.com/health-plans/navinet-basics/user-guide/adding-health-plan-your-office.

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 co-insurance, copayments and deductibles from those enrolled in the QMB Program, including those enrolled in Medicare Advantage and other Part C plans. If you are a PCP, THP has coded your patient rosters with a symbol to help you identify which of your patients meet this income level. Patient rosters are available on our secure provider portal located at myplan.healthplan.org.

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

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

1.800.MEDICARE (1.800.633.4227).

Keep Provider/Practice Info Up-to-Date

It is very important to remember to contact The Health Plan with any changes to your office location, telephone 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 our corporate website, 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.

Breathalyzer Testing

Change Announcement

Please be advised that effective July 1, 2020, The Health Plan will deny all breath alcohol testing (procedure code 82075) performed in conjunction with any urine drug screen, other than dipstick point-of-care testing (POCT), billed with procedure code 80305. Providers using more complex urine drug testing, such as procedure code 80307 or a definitive screen, are encouraged to include alcohol as a screened substance.

The Health Plan is making this change in order to ensure the proper utilization of urine drug testing associated with pain management clinics and substance use disorder practitioners and facilities. We would like to remind providers that urine drug testing is most effective when 1) individualized rather than routine, 2) randomized, and 3) conducted in conformance with principles of assessment recommended by the American Society for Addiction Medicine (asam.org/docs/default-source/quality-science/appropriate_use_of_drug_testing_in_clinical-1-(7).pdf?sfvrsn=2). ASAM strongly recommends against routine use of definitive testing. Please review the white paper at the link above. As always, all clinical procedures can be subject to post payment review for medical necessity.

This change affects the following lines of business: Commercial, Medicaid, Medicare.

Self-funded groups default to the individual group plan document.

Please direct any questions to the Clinical Services Department at 1.800.624.6961, ext. 7644.

Attention: Paper Claim Submitters

The Health Plan accepts the current standard paper claim billing forms:

- CMS 1500 (02/12) professional claim form
- UB-04 hospital claim form
- ADA dental claim form

Effective July 1, 2020, only original claim forms (red ink) are accepted. Copies made from an original claim form, faxed or scanned claims (black ink) will be rejected.

Handwritten claims are also not acceptable. As an alternative to paper claims, providers may submit claims electronically, free of charge, via The Health Plan's provider portal. The portal is accessed via myplan.healthplan.org. Contact your provider engagement representative to learn how.

Claim forms must be completed in their entirety. The Health Plan requires that all claims are submitted with accurate and current CPT-4, HCPCs, and ICD-10 codes, as appropriate.

All services must be billed within 180 days from the date of service for Commercial, Medicare and Medicaid members.

Self-funded lines of business default to the individual group plan document. Claims questions may be directed to The Health Plan's Customer Service Department at 1.800.624.6961.

Medicare Advantage

Vision Providers and Copays

THP vision providers (ophthalmologists and optometrists) may not collect a copay from Medicare Advantage members for Medicare covered eye exams or non–Medicare routine vision exams (including diabetic eye exams). To see a complete description of Medicare covered vision services please visit: myplan.healthplan.org, "Resource Library," "Announcements."

Drug Prior Authorization

Submit Requests Electronically

Save time by submitting prescription drug prior authorization requests electronically via THP's website. Visit this link to access the Formulary Exception Request Form to submit your request directly to THP: healthplan.org/formulary-exception-request-form. Feel free to contact THP's Pharmacy Department at 1.800.624.6961, ext. 7914 should you have any questions or require assistance.

NDC Requirements

Outpatient Medical Claims

All outpatient medical claims for provider-administered drugs must contain a Healthcare Common Procedure Coding System (HCPCS) code, a National Drug Code (NDC) number, the NDC unit of measure, and the NDC quantity. Failure to submit required information will result in a denied claim.

Select Medicare Part B Drugs

Step Therapy Required

In the near future, The Health Plan will require step therapy on select Medicare Part B drugs. Information for this process will be forthcoming so stay tuned!

If you have any questions, please call Pharmacy Services at 1.800.624.6961, ext. 7914.

REMINDER: CMS Annual Training

Compliance and fraud, waste and abuse (FWA) training should be completed on an annual basis. Training may be completed through your own internal compliance program or by using training documents provided by The Health Plan which are available at myplan.healthplan.org, "Resource Library," "Compliance." Training should be completed within 90 days of the initial hire date or the effective date of contracting and at least annually thereafter. Providers are required to maintain evidence of training for 10 years. This may be in the form of attestations, training logs or other means.

Clinical Practice Guidelines Available Online

The Health Plan and participating practitioners routinely review and update the preventive health guidelines and 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.

Billing Behavioral Health Services

in a Physician's Group or Individual Medical Practice

The Health Plan requires credentialing of all licensed behavioral health practitioners operating within a physician's practice. The requirement for credentialing also applies to FQHC/RHCs.

Unlicensed personnel may not bill for behavioral health services within a physician's practice with the exception of supervised psychologists officially approved by the WV Board of Examiners of Psychology. THP will only reimburse supervised psychologists when providing services to THP's Medicaid members. A supervised psychologist must appear on the web page of the Board of Examiners of Psychologists in WV located at the following website: psychbd.wv.gov/license-info/License-Search/Documents/2020-4-6 Active Supervisees.pdf.

Please note that this guideline does not apply to physician's offices located within licensed behavioral health centers. Please further note that The Health Plan, in conformity with mental health parity rules, does not require prior authorization for clinic-based behavioral health outpatient services. The behavioral health authorization list is available at myplan.healthplan.org, "Pre-Authorizations," "Pre-Authorization Lists."

More detailed guidelines for Medicare and Medicaid billing in a group practice may be found at: myplan.healthplan.org "Resource Library," "Announcements."

Required by CMS

Cultural Competency Training

Cultural competency training is required by The Centers for Medicare and Medicaid Services (CMS) and tracked by The Health Plan. Providers completing cultural competency training are noted in The Health Plan's Provider Directory.

The Health Plan offers cultural competency training through the provider engagement representative assigned to your county or via a cultural competency training slide deck. The presentation is located at myplan.healthplan.org, "Provider Resources," "Training and Education." Upon completion of training, please sign and return the attestation form.

Prior Authorization Required for Facility Transfers

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