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/resources/provider-manual.

Inside this issue …

The Health Plan

2020 Primary Care

Quality Incentive Program

The Health Plan (THP) values and recognizes the critical role primary care plays in improving the health and well-being of the communities we serve. In recognition of the importance of preventative care, primary care physician groups will receive a $100 incentive payment for coordinating and delivering care to SecureCare (HMO) and Secure Choice (PPO) Medicare Advantage members as part of the 2020 Primary Care Quality Incentive Program (PCQIP).

Eligible preventative measures in this Medicare Advantage incentive program include:

- Breast cancer screenings
- Diabetic eye exams
- Osteoporosis management in women who had a fracture
- Statin therapy for patients with cardiovascular disease
- Statin use in persons with diabetes (SUPD)

Qualifying care will be rendered from date of service July 1, 2020 through date of service December 31, 2020.

Incentive payments will be calculated and paid to the assigned primary care physician practice, based on claims received by February 28, 2021. PCQIP payment will be made by March 31, 2021.

Your THP practice management consultant will assist you in identifying your SecureCare and SecureChoice members with current care gaps for the incentivized measures.

We look forward to working with you in advancing the health outcomes for your patients, our members, during the remaining months of this unique year of COVID-19. We appreciate your dedication and commitment to rendering quality care in our community.

Psychological Testing and ABA Services

Removal of Prior Authorization Requirements

The Health Plan is pleased to announce that effective September 1, 2020, all prior authorization requirements for psychological testing and Applied Behavior Analysis (ABA) Services will be removed.

This will be applied across the following THP product lines: Fully-Insured (including Health Maintenance Organization (HMO), Preferred Provider Option (PPO), Point-of-Service (POS) plans), West Virginia Public Employees Insurance Agency (PEIA), Medicare Advantage (including SecureCare HMO, SecureChoice PPO and Dual Eligible Special Needs Plans D-SNP), and West Virginia Mountain Health Trust (including WV Medicaid, SSI and WV Health Bridge).

The following CPT codes no longer require prior authorization:	
Psychological Testing CPT Codes	ABA Services CPT Codes
96112	H0031
96113	97151
96130	97152
96131	97153
96132	97154
96133	97155
96136	97156
96137	97158
96138**	
96139**	
96146	
96116	
** Not a Covered Medicaid Benefit	

Self-funded groups default to the individual group plan document. Please contact THP regarding prior authorization requirements.

Please note that the required credentials for provision of these services for the Mountain Health Trust line of business are outlined in the Bureau for Medical Services (BMS) provider manual. Other lines of business will adhere to The Health Plan's contract and the professional ethics expected of the behavioral health profession.

All ABA services must be provided by a provider with one of the following credentials: BCBA, RBT, BAT or BCaBA, as identified by service requirement.

All psychological assessments must be performed by a licensed psychologist. BMS permits a supervised psychologist to conduct assessments under the supervision of a licensed psychologist for WV Mountain Health Trust members.

For non-Mountain Health Trust members, a suitably qualified technician may receive reimbursement for performing psychological and neuropsychological testing (CPT codes 96138 and 96139).

The Health Plan reserves the right to conduct post-payment review to support medical necessity and appropriate utilization of services.

Please contact THP at 1.800.624.6961 with questions.

Claim Status Inquiry With Attachments Now Available!

Effective September 24, 2020, The Health Plan is implementing the Claim Status Inquiry transaction for providers enrolled with NaviNet. You will have the ability to attach PDF documents to your pended, denied & finalized/paid claims.

For additional details regarding the new transaction, please review the NaviNet Open Claim Status Inquiry New Feature Guide.

What Do You Need To Do To Access This?

NaviNet will automatically add the Claim Status Inquiry transaction to your workflow for The Health Plan if you are a registered NaviNet user. If you are not, register today at NaviNet.Navimedix.com.

Provider Delivery Services

Formerly Provider Engagement Department

THP recently redesigned and retitled our Provider Engagement Department to better serve the needs of our provider community. The department is now the Provider Servicing Department and is comprised of Practice Management Consultants (PMCs), an elite resource for practices and health systems regarding quality improvement initiatives, education, and best practice standards for efficiency. Provider Operation Specialists, a new role created for the department, will work in conjunction with the PMCs on claims trends and data analysis to proactively identify opportunities for partnership improvements.

In addition to the Provider Servicing team, The Health Plan offers other solutions for questions related to basic operational functions. The Customer Service Department is available for inquiries, such as EDI enrollment and prior authorization requirements. They may be reached at 1.877.847.7901. For the convenience of our providers, the NaviNet platform is now available 24 hours a day, seven days a week to verify member eligibility, benefits, and claim status inquiry.

Our team looks forward to delivering an exceptional experience to our providers and their administrative teams.

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.

Prior Authorization Required for Facility Transfers

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

Medical Records Timely Return

Providers have a contractual obligation to provide The Health Plan with medical records when requested. The contract language states the following, "The Health Plan shall be entitled to obtain copies of Member's records at no expense. Physician's obligations under this paragraph may be satisfied by providing a copy of records requested within a reasonable period of time."

West Virginia CHIP

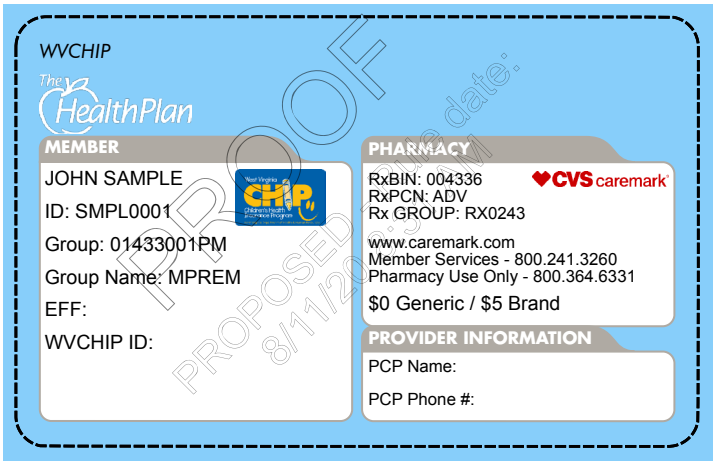
Now an Option for The Health Plan Mountain Health Trust Members

The West Virginia Children's Health Insurance Program (WVCHIP) is joining West Virginia Mountain Health Trust (MHT) managed care programs effective January 1, 2021. The Health Plan is an option for the WVCHIP population to choose for management of their health care needs.

The Health Plan is hosting live webinars discussing the WVCHIP transition and answering frequently asked questions.

Webinar dates and times with the registration information will be forthcoming.

Please see a sample of the member card that our members will present to you at the time of service.



WV CHIP Prior Authorization Update

The West Virginia Children's Health Insurance Program (WVCHIP) is transitioning members to managed care on January 1, 2021. The WVCHIP population will be managed under the Mountain Health Trust (MHT) program. The Health Plan is one of three managed care organizations contracted with the Bureau for Medical Services (BMS) to manage the healthcare benefits for the MHT population. Medical and behavioral health utilization management functions for WVCHIP members will transfer from KEPRO to the appropriate managed care organization that participates in MHT on January 1, 2021.

Important Dates

December 24, 2020 – Last day that non-emergent medical and behavioral health prior authorization (PA) requests for services will be processed by KEPRO. Emergent inpatient medical and behavioral health PA requests will continue to be processed by KEPRO until December 31, 2020. There will be no changes in the submission process to KEPRO. Contact KEPRO at 1.888.571.0262 for questions about PA requests.

December 31, 2020 – Last day that PA requests for services scheduled or admissions occurring on or before December 31, 2020 should be submitted to KEPRO.

J***anuary 1, 2021*** – First day that all PA requests for services scheduled on or after January 1, 2021 should be submitted to The Health Plan for WVCHIP members.

Reminder

CMS Annual Training

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.

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 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 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.

Mail Order Prescriptions

Equal No Copays for THP Medicare Part D Members

Refilling prescriptions has been shown to be a major barrier to medication adherence for patients with chronic conditions. Prescriptions for 90-day supplies of medications have not only been shown to improve adherence, but also to save money for patients. The Health Plan Medicare Part D members have no copay for a 90-day supply of formulary generic medications when using Express Scripts mail order pharmacy. The Health Plan is encouraging providers to write prescriptions for a 90-day supply for members with chronic conditions.

Case Management Program – Here to Help

The Health Plan has a team of registered nurse case managers who coordinate health care services for members with catastrophic illnesses, injuries or behavioral health problems. If you have a patient you believe would benefit from the case management program, contact our Clinical Services Department at 1.800.624.6961, ext. 7644.

The Health Plan's website, healthplan.org provides detailed information about our case management program and even provides an online Physician Case Management Referral Form to easily refer one of your patients.

Clinical Guideline Changes

eviCore Utilization Management

In an effort to ensure the optimal level of care and service delivery, eviCore is implementing a program enhancement to the prior authorization process for post-acute care (PAC), home health (HH), and durable medical equipment (DME) services.

Effective September 1, 2020, eviCore began to utilize MCG™ evidence-based care guidelines as the basis of medical determinations for skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), and home health (HH) programs.

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.

Benefit Updates

Adult Medicaid Dental

Effective November 1, 2020, The Health Plan (THP) is updating our existing guidelines related to dental benefits for adult Medicaid members.

Dental services are limited to emergent procedures to evaluate and treat fractures, reduce pain or eliminate infection. Specifically, fractures of the mandible and maxilla, biopsy, removal of tumors, and emergency extractions are covered services for THP Medicaid enrolled adults 21 years of age and older.

View the BMS Provider Manual Chapter 505 (Oral Health Services) section located at dhhr.wv.gov, "Providers," "Manual."

Prior authorization may be required for specific services and when service limits are exceeded.

Documentation Requirements Update:

- Documentation is required for services marked in yellow on the reference grid below and may be requested for procedures not marked in yellow.
- Dental procedure codes D7780 and D7999 require prior authorization.
- When submitting imaging, please send copies of current, diagnostic images. Images will not be returned.

Please contact THP's Medicaid Customer Service at 1.888.613.8385 with any questions.

Click here to view full billing guidelines located at healthplan.org/providers/medicare-medicaid/wv-medicaid.

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.

Medicaid Health Management Systems and The Health Plan

The Health Plan (THP), has contracted with Health Management Systems, Inc. (HMS) to perform third party liability and related revenue recovery services. By Federal statute (42 U.S.C. 1396a (25), 1396b (d) (2) and 1396b (O)), Medicaid is the payer of last resort. THP, in its contract with the West Virginia Bureau for Medical Services' Medicaid Program, is required to recover any payments made on claims for which other health insurance is identified.

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.

Continuation of Telehealth Services

The Health Plan is continuing to allow ALL telehealth services for THP members for Medicaid, Medicare, Commercial, and PEIA through December 31, 2020.

There are no copays for Medicaid and Medicare telehealth services regardless if the telehealth services are related to COVID-19.

There are no copays for Commercial and PEIA members if the telehealth services are related to COVID-19.

The regular copay applies for Commercial and PEIA members seeking services non-related to COVID-19 from their PCP/Specialists.

Please note - providers will need to contact customer service for ALL self-funded plans regarding telehealth as the employer makes the decision for their group.

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