



ProviderFocus

A Publication of The Health Plan • January 2021

Provider Practitioner Manual

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

Inside this issue ...

The Special Investigations Unit	2
Member Rights and Responsibilities	2
Prior Authorizations	3
Hours of Operation Reminder to Providers	3
REMINDER: Signatures, Credentials and Dates are Important	3
D-SNP Required Annual Training	3
Swing Bed Care Billing Instructions	4
Peer Recovery Support Services (PRSS)	4
Information Regarding New Benefits	5
WVCHIP Available for THP MHT Members	6
Keep Provider/Practice Info Up-to-Date	6
Low Income Medicare Beneficiaries	6
Member ID Numbers	7
THP Affirmative Statement Regarding Incentives	7
REMINDER: CMS Annual Training	7
Clinical Practice Guidelines Available Online	7
Continuity and Coordination of Care	8
Prior Authorization Required for Facility Transfers	8



The “Patient Experience”

And how it impacts your practice

The patient experience with healthcare is becoming increasingly important to all of us within healthcare. According to the Agency for Healthcare Research and Quality (AHRQ), the patient experience “encompasses the range of interactions that patients have with the health care system, including their care from health plans, and from doctors, nurses, and staff in hospitals, physician practices, and other health care facilities.”

In the U.S., estimates show that active patient choices can impact more than 60 percent of health care spending. While the patient experience includes many elements of healthcare quality, patient satisfaction, and convenience of care, it is important to understand not only what constitutes the patient experience, but also how you and your staff can support a positive patient experience.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey that is performed annually, assesses your patients' experiences and satisfaction with health care. Here are some ideas for helping improve your patients' healthcare experience while improving health outcomes, based on our most recent survey results.

Annual flu vaccines: 25% of The Health Plan's SecureCare and SecureChoice members surveyed said they were NOT advised by a healthcare professional to get an annual flu vaccine; far more within THP commercially insured and WV Medicaid populations said they were NOT told they should receive a flu vaccine.

What you and your staff can do:

- Ask patients if they have received the flu vaccine as well as other vaccines, and recommend they receive them when appropriate.
- Help guide your patients to a pharmacy where they can receive the needed vaccines if you do not provide them in your office setting. 🍏

The Special Investigations Unit

Detecting, Preventing, and Correcting Fraud, Waste and Abuse

Medicaid and Medicare guidelines require The Health Plan to have an effective program in place to prevent, detect, and correct fraud, waste and abuse. The Health Plan values its relationship with providers and recognizes the importance of providing valuable care to the community. The Health Plan is committed to ensuring quality care for its members and proper payment to providers for services rendered. Safeguarding payment integrity is an integral part of maintaining this mutually beneficial relationship and honoring the commitment to The Health Plan's network and its members, as well as complying with federal regulations.

The Special Investigations Unit (SIU) plays a vital role in detecting, preventing, and correcting fraud, waste and abuse, ensuring payment integrity, and recovering overpayments as required by state and federal regulations. SIU activities may include, but are not necessarily limited to, data mining, pre- and post-payment reviews, site visits, provider education, audits, and the facilitation of provider self-audits. In the event fraud is suspected, information is referred to the appropriate regulatory authorities and/or law enforcement.

The SIU utilizes a skilled team capable of analyzing, auditing, and investigating claims. Being contacted by the SIU does not mean there has been an accusation of fraud. Providers may be contacted by the SIU as a result of routine post-payment monitoring, or in response to a specific concern. Providers must comply promptly with requests for records or other information to ensure the timely completion of audits and reviews. 🍏

The Health Plan **COMPLIANCE**
FRAUD, WASTE & ABUSE
HOTLINE

Anyone
can report
suspected **fraud** or issues of
noncompliance

- Employees
- Volunteers
- Providers
- Members
- Vendors
- Subcontractors

Dial: 1.877.296.7283
Email: siu@healthplan.org

*You may report anonymously.
There can be **NO** retaliation against you for
reporting suspected noncompliance in good faith.*

Member Rights and Responsibilities

We would like to remind all provider offices that the member rights and responsibilities can be found in the Provider Practitioner Manual in Section 3 and Section 5_21. 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. 🍏

Making the Process Easier for You!

Prior Authorizations

We are pleased to announce that The Health Plan has updated its prior authorization list and developed a CPT Code level table for ease of reference.

This list of services and CPT Codes, along with some newly developed medical policies, will be on The Health Plan's Secure Provider Portal at myplan.healthplan.org.

This list is designed to improve communication to our provider community and to reduce the administrative burden on our providers.

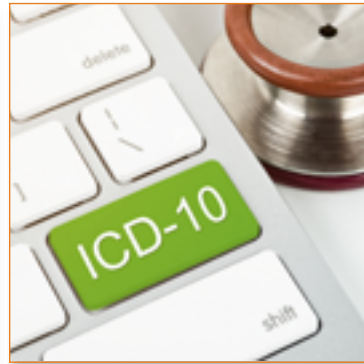
This new feature enables providers to search a CPT code, verify if a prior authorization is required by line of business (Medicare, Medicaid/WVCHIP, Commercial or Self-Funded), and direct you to the applicable vendor.

For detailed information log onto myplan.healthplan.org, choose "pre-authorizations," from the menu on the left and then choose "pre-authorization lists."

In addition to updated authorizations providers can find the following new clinical policies:

- Experimental Investigation Policy
- Medical Necessity Review Policy
- Non-Invasive Prenatal Genetic Testing for Identification of Chromosomal Aneuploidy Policy
- Genetic Testing for Hereditary Breast and Ovarian Cancer Syndrome Policy

All providers are encouraged to review the updated list for changes that are effective January 1, 2021. 🍏



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) require 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 under "Resource Library," "Training and Education." 🍏



WV Medicaid Recipients

Swing Bed Care Billing Instructions

The Health Plan now reimburses for swing bed care for eligible acute care and critical access hospitals for WV Medicaid recipients. This benefit is available through the duration of the COVID-19 Public Health Emergency.

Members are required to have been inpatient for a medical necessity stay for at least 3 calendar days before being eligible for transfer.

Providers are not required to submit prior authorization for transition; however, providers are required to notify THP case management for any member meeting transition criteria from an acute care bed to a swing bed before completing the transfer. Failure to notify THP may result in claim denial.

Providers must submit two separate UB04 claims, one for each stay type and utilize bill type 181 on the claim designating the use of the swing bed.

Only members meeting skilled nursing facility level of care qualify for transition to a swing bed. THP reserves the right to conduct post-payment review to determine if criteria was met for each member.

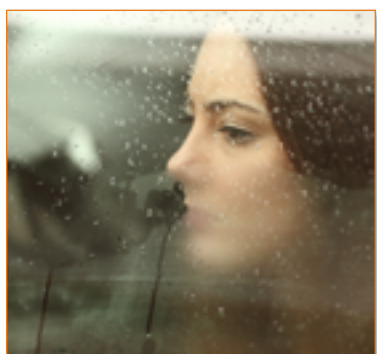
Acute care facilities will be reimbursed at \$238 per diem. Critical Access Hospitals will be reimbursed at the facility-specific per diem swing bed rate provided by DHHR.

Facilities should submit their Medicaid claims using their Medicaid NPI, not their Medicare NPI. 🍏

Peer Recovery Support Services (PRSS)

Prior Authorization Changes

In response to provider requests and with their consultation, effective January 1, 2021, The Health Plan (THP) is altering prior authorization protocols for Peer Recovery Support Services (billing code H0038) for the West Virginia Medicaid line of business. Due to provider feedback, THP has amended the previous policy to include access



to 180 units of PRSS service per month without authorization for individuals with a diagnosis of substance use disorder. Additional units over 180 per month will require authorization.

Complete billing guidelines for PRSS are available on THP's public website at healthplan.org, "For Providers," "Medicare and Medicaid," "WV Medicaid," "Provider Billing Instructions."

Highlights of prior authorization changes are as follows:

- Agencies may provide 180 units of PRSS services monthly without authorization.
- Additional units may be made available utilizing the authorization process, if the provider can demonstrate medical necessity for the additional units of service. Those additional units will only be available for use to the end of the month in which the units are requested as on the first day of the next month, another 180 units will again be available.

Feel free to contact the Medicaid Customer Service Department at 1.888.613.8385 or your practice management consultant for questions. Access practice management consultant contact information for your county on our website.

These policy revisions can be found at myplan.healthplan.org, "Announcements," "Announcing Amendments to the Authorization Changes for Peer Recovery Support Services (PRSS)." 🍏

WV Medicaid Adult Population Information Regarding New Benefits

Effective January 1, 2021, The Health Plan (THP) is adding the Adult Preventative and Restorative Dental Benefit for our Medicaid members over the age of 21. This new benefit has a \$1,000 limit per calendar year. Providers are reimbursed at the current WV Medicaid dental fee schedule. Any remaining balance above \$1,000 will be the responsibility of the member. Dental providers will direct bill the member for any outstanding balance based off of the Medicaid fee schedule.

The comprehensive codes set and service limitations can be found within the Bureau for Medical Services (BMS) provider manual located at: dhhr.wv.gov/bms/Pages/Chapter-505-Dental-Services-.aspx

The Health Plan is administering the claims processing for this new benefit. Please do not submit claims to Skygen for claims processing. Claims can be sent electronically if you utilize Change Healthcare clearinghouse or be mailed to 1110 Main Street Wheeling, WV 26003.

Dental procedures listed in the grid below require prior authorization. Please submit requested documentation for review to The Health Plan.



CDT Code	Service Type	Frequency Limitations	Documentation Required (THP)
D2740, D2750, D2751, D2752, D2791	Crown	1 per tooth every 5 years	Pre-operative periapical or bitewing
D2950	Core build up	1 per tooth per year	Pre-operative periapical or bitewing
D2952, D2954	Post and core	1 per tooth every 3 years	Pre-operative periapical
D3346, D3347, D3348, D3410, D3421	RCT retreatment & apicoectomy	1 per tooth per lifetime	Pre-operative periapical
D4210, D4211	Gingivectomy	1 per quadrant per calendar year	Provider progress notes, current full mouth periodontal charting
D4341, D4342	Scaling & root planing	1 per quadrant per calendar year	Full mouth series or panoramic with bitewings, current full mouth periodontal charting
D4346	Scaling in presence of inflammation	1 every 2 years	Provider progress notes, full mouth periodontal charting
D7250	Surgical removal, unexposed root	1 tooth per lifetime	Pre-operative radiographic image
D9630	Other drugs or medicaments, by report	n/a	Provider progress notes
D9944, D9945	Occlusal guard	1 per arch every 5 years	Provider progress notes
D9999	Unspecified procedure	n/a	Provider progress notes

Other dental procedures covered under the Adult Preventative and Restorative Dental Benefit may be reviewed by THP on a request basis.

Providers who are not contracted with The Health Plan may visit our website at healthplan.org/providers/overview/join-our-network for more information about becoming a participating provider.

Dental providers are strongly encouraged to contact THP's Customer Service at 1.888.613.8385 to determine if any amount has been used against the member's \$1,000 limit before administering any services. This will help reduce the risk of non-payment.

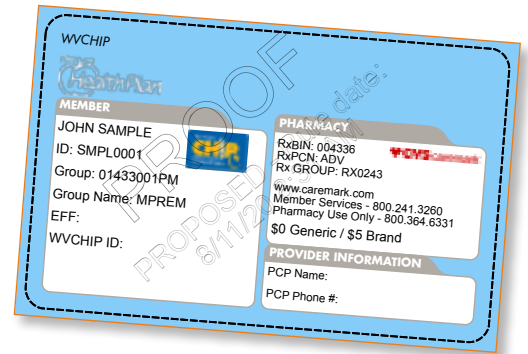
We look forward to working with you and your staff in administering this new benefit for our WV Medicaid members. 🍏

WVCHIP Available for THP MHT Members

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.

Please see the sample member card to the right. Our members will present this card to you at the time of service. 🍏



Keep Provider/Practice Info Up-to-Date

Help Us Help Members 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 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. 🍏

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](https://www.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.

For questions, please call 1.800.MEDICARE (1.800.633.4227). 🍏

Member ID Numbers

Remember to Use the Suffix

Please note it is important when identifying members you use the ID number complete with the suffix at the end.

Outlined in green is an example of a member ID number on a SecureCare HMO card however, the member ID number is in the same location for all lines of business.

This information is necessary to assist our customer service representative and claims payers in identifying the appropriate member. 🍏



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. 🍏

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 nonauthorizations, 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. 🍏



Clinical Practice Guidelines Available Online

The Health Plan and participating practitioners regularly 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. 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. 🍏

Continuity and Coordination of Care

Between 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.

All federal and state confidentiality laws must be followed. The Health Plan expects that this information be shared accordingly and recognizes the right to keep progress notes private.

The Health Plan also understands that there are special situations where information cannot be shared. A continuity of care consultation sheet is available on The Health Plan's website for use in facilitating this communication at healthplan.org.

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

Prior Authorization Required for Facility Transfers

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

The Health Plan • 1110 Main Street • Wheeling, WV 26003-2704 • 1.800.624.6961 • healthplan.org



1110 Main Street
Wheeling, WV 26003-2704