

Provider Procedural Manual

Corporate Office

1110 Main Street
Wheeling, WV 26003

P: 1.800.624.6961

F: 1.740.699.6169

TTY: 711

healthplan.org

Effective 04/04/2022

This manual is intended for the sole use of the physicians of The Health Plan. Any reproduction or distribution of any part of this manual without written consent from The Health Plan is prohibited.





Table of Contents

Section 1 - Welcome

Welcome to The Health Plan! 2

Mission Statement..... 2

About Us..... 2

Provider Delivery Services..... 3

Provider Quick Reference Guide 4

Section 2 – Physician Availability

Physician Availability 7

Primary Care Physician Responsibilities 8

Primary Care Physician Guidelines 9

PCPs Encouraged to Screen for Behavioral Health Needs 10

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment..... 10

Secondary Care Physician Guidelines 11

Specialist Guidelines 12

Physician Care of Self or Family 13

Section 3 – Member Benefits

Member Benefits..... 15

Product Matrix..... 15

Commercial Health Maintenance Organization (HMO) Plans..... 17

Commercial Point of Service (POS) Plans 18

Commercial Preferred Provider Organization (PPO) Plans 19

Sample Commercial ID Cards..... 20

Administrative Services Only (ASO) Self-Funded Employer Groups 21



| | |
|--|----|
| Sample Self-Funded ID Cards | 21 |
| SecureCare HMO Medicare Advantage Plan | 22 |
| SecureChoice PPO Medicare Advantage Plan | 22 |
| D-SNP Program (Medicare Advantage Special Needs Plan) | 23 |
| Sample Medicare ID Cards..... | 24 |
| Mountain Health Trust (MHT) Program | 25 |
| Sample WV Medicaid ID Card | 26 |
| Sample WVCHIP ID Card | 26 |
| Vision Service Benefit | 27 |
| Sample Vision Provider Reimbursement Voucher | 28 |
| The Health Plan's Members' Rights and Responsibilities Statement | 29 |

Section 4 – Medicare

| | |
|---|----|
| SecureCare HMO Medicare Advantage Plan | 32 |
| SecureChoice PPO Medicare Advantage Plan | 32 |
| D-SNP Medicare Advantage Special Needs Plan..... | 33 |
| Coordination of Benefits Medicare Advantage Secondary Payer | 34 |
| THP Insurance Company Medicare Supplemental Plans..... | 34 |
| Medicare Non-Covered Service Guidelines | 35 |
| CMS Quality Measures/Standards | 37 |
| Appointment of Representative Statement for a Medicare Member | 38 |
| Appointment of Representative Forms | 38 |
| Notice of Medicare Noncoverage (NOMNC) | 39 |
| Medicare Outpatient Observation Notice (MOON) | 40 |
| Medicare Appeals Overview | 41 |
| Notice of Medicare Hospital Discharge Appeals Notices..... | 42 |



Low Income Medicare Beneficiaries 42

Medicare Provider Rights and Responsibilities 43

SecureCare/SecureChoice Rights and Responsibilities 45

Section 5 – Mountain Health Trust (MHT) Program

Mountain Health Trust (MHT) Program 54

Mountain Health Trust ID Cards 55

WV Health Bridge ID Card..... 56

WVCHIP ID Card 56

Medicaid Benefits and Exclusions at a Glance 57

WVCHIP Benefits at a Glance 65

WVCHIP Benefit Exclusions 73

Additional Resources for Mountain Health Trust Members..... 77

Hours of Operation..... 79

Cultural Competence 79

HealthCheck (EPSDT) 80

Medicaid Copays..... 81

Medicaid Prescription Benefit..... 82

WVCHIP Copays 83

Mountain Health Trust Out-of-Network Non-Patient Facing Provider Reimbursement..... 85

WVCHIP Emergency Services by Non-Participating Providers..... 85

Family Planning..... 86

Local Health Departments..... 86

Staffing 87

Surgical Consent Forms 87

Pregnancy and Newborn Enrollment..... 88



| | |
|--|-----|
| Women's Access to Health Care | 89 |
| Tobacco Cessation | 89 |
| Diabetes | 89 |
| Medicaid Behavioral Health Services..... | 90 |
| WVCHIP Behavioral Health Services | 90 |
| Mountain Health Trust Behavioral Health Credentialing and Billing Guidelines | 91 |
| Medicaid Adult Dental..... | 94 |
| Medicaid Children's Dental..... | 95 |
| Immunization Registry | 96 |
| Appeals and Grievances | 96 |
| Mountain Health Trust Statement of Members' Rights..... | 100 |
| Mountain Health Trust Members' Rights | 103 |
| Provider Reporting Requirements | 105 |
| Provider Responsibilities and Reimbursement | 106 |
| Changes to Provider Fee Schedules | 107 |
| Alternative Payment Models | 108 |
| Marketing Guidelines | 109 |
| West Virginia MHT Provider Required Provisions | 112 |
| Medicaid Drug Testing Policy | 118 |
| Breathalyzer Testing..... | 118 |
| Medicaid Transplant | 119 |
| Non-Par Provider..... | 119 |
| Prior Authorization..... | 119 |
| Medicaid Chiropractic Service | 119 |
| Physical and Occupational Therapy..... | 119 |



| | |
|---|-----|
| Inpatient Claims..... | 119 |
| Medicaid NDC Rebate Eligible Drugs | 120 |
| Readmissions Review Occurring Within 30 Days | 121 |
| Medicaid Substance Use Disorder (SUD) Goals | 121 |
| SUD Provider Training and Education Requirements..... | 121 |
| Peer Recovery Support Services | 122 |
| Medicaid ER All-Inclusive..... | 122 |
| Outpatient Services for Acute and Critical Access Hospitals | 122 |
| Paper Claim Submissions | 123 |
| Disclosure | 123 |
| Medicaid Value Add Brochure | 124 |

Section 6 – Office Copays, Medical Copays, Co-insurance & Deductibles

| | |
|--|-----|
| Office Visit Copays, Medical Copays, Co-insurance & Deductibles..... | 127 |
|--|-----|

Section 7 – Clinical Services

| | |
|---|-----|
| Clinical Services Introduction..... | 130 |
| Medical Prior Authorization and Notification Requirements | 130 |
| Palladian Health | 131 |
| eviCore healthcare..... | 132 |
| Telephone Directory..... | 133 |
| Nurse Information Line | 134 |
| Admissions/Concurrent Review Process | 134 |
| Prior Authorization/Referral Management Review Criteria | 136 |
| InterQual® Review | 137 |
| Requests for Second Opinion | 137 |



| | |
|---|-----|
| Specialist Coordination of Health Care Services | 138 |
| Member Wellness, Prevention & Health Promotion | 139 |
| Care Coordination | 139 |
| Care Navigation | 140 |
| Complex Case Navigation | 140 |
| Chronic Disease Management Program | 142 |
| Perinatal Care Program | 142 |
| Advance Care Planning | 145 |
| Leadership and Committees | 145 |
| Annual Program Evaluation | 147 |
| Forms, Tools and Worksheets | 147 |

Section 8 – Population Health

| | |
|------------------------------------|-----|
| Population Health Management | 149 |
| Quality Measures and HEDIS® | 150 |

Section 9 – Quality Improvement

| | |
|---|-----|
| Introduction | 152 |
| Quality of Clinical Care Indicators | 153 |
| Customer Satisfaction Quality Indicators | 153 |
| Review Process for Clinical and Customer Service Quality Indicators | 154 |
| Continuity and Coordination of Care | 155 |
| Standards for Access to Care and Services | 156 |



Section 10 – Behavioral Health

| | |
|---|-----|
| Introduction..... | 159 |
| Review Criteria..... | 160 |
| InterQual® Review | 160 |
| Behavioral Health Prior Authorization and Notification Requirements | 160 |
| Review of Inpatient Treatment, Detoxification, Rehabilitation of Substance Use Disorders and Observation..... | 161 |
| Outpatient Prior Authorization and Referral Management | 164 |
| Drug Screening and Testing..... | 173 |
| Credentialing and Billing | 174 |
| Annual Program Evaluation | 175 |
| Access to Care | 176 |
| Continuity and Coordination of Care | 176 |
| Behavioral Health Services Forms..... | 177 |
| Telehealth Services..... | 178 |
| Follow-Up Care After Behavioral Health Admissions | 178 |
| Standards and Guidelines of Care | 179 |

Section 11 – Pharmacy Services

| | |
|--|-----|
| Introduction..... | 181 |
| Obtaining a Prescription..... | 183 |
| Pharmacy Prior Authorization and Notification Requirements | 184 |
| Formulary | 184 |
| Prior Authorizations | 186 |
| Prior Authorization Forms | 186 |



Section 12 – Billing

| | |
|--|-----|
| Billing Procedures..... | 189 |
| Never Events and Avoidable Hospital Conditions | 192 |
| Electronic Billing – Documentation Submission | 195 |
| Notice of Readmissions Review Occurring Within 30 Days | 195 |
| Disputes and Arbitration | 196 |

Section 13 – EDI

| | |
|---|-----|
| Introduction | 198 |
| Trading Partner Electronic Submitters | 199 |

Section 14 – Coordination of Benefits (COB)

| | |
|---|-----|
| Coordination of Benefits..... | 201 |
| Mountain Health Trust Members..... | 201 |
| Order of Benefit Determination Rules..... | 202 |
| Procedures Regarding COB | 203 |
| Medicare Crossover Notice | 205 |
| Medicare Primary Payment Example..... | 206 |

Section 15 – Payment Voucher and Claims

| | |
|---|-----|
| Payment Voucher Introduction..... | 208 |
| Claims in Process | 208 |
| Resubmission of Claims Denied for Documentation | 208 |
| Process to Resubmit a Denied Claim | 210 |
| Claim Resubmission Form | 210 |
| Overpayments and Offsetting..... | 211 |



Section 16 – Credentialing

Credentialing 214

Recredentialing 215

Practitioner's Credentialing/Recredentialing Rights 216

Office Orientation and Medical Site Survey Form 217

Office Orientation and Behavioral Health Site Survey Form 217

Standards for Participation 218

Initial Certification..... 221

The Health Plan Standards for Patient Records 222

Medical Records and Confidentiality Statement..... 226

Signature Log Form 227

Telephone Message Form 227

Section 17 – Compliance, SIU and FWA

Fraud, Waste and Abuse Regulations and Guidelines 229

Special Investigations Unit..... 231

Compliance Through Training 232

Compliance Through Reporting..... 234

FWA Hotline Poster 234

HIPAA Privacy and Security 236

Section 1

Welcome





Welcome to The Health Plan!

The Health Plan thanks you for your participation and care of our members. We want to ensure that you are able to locate needed information in a quick and efficient manner. The purpose of this manual is to give you a resource for working more effectively in partnership with The Health Plan.

Although this provider manual is reviewed and updated twice a year, providers should check The Health Plan's portal and website for the most current information.

Mission Statement

"Established as a community health organization, The Health Plan delivers a clinically-driven, technology-enhanced, customer-focused platform by developing and implementing products and services that manage and improve the health and well-being of our members. We achieve these results through a team of health care professionals and partners across our community."

About Us

As a community health organization and one of the largest locally managed care organizations in Ohio and West Virginia, The Health Plan delivers a clinically-driven, technology-enhanced, customer-focused platform by developing and implementing products and services that manage and improve the health and well-being of our members. We have been achieving these results through a team of health care professionals and partners from across our communities since 1979.

The Health Plan is a not-for-profit, 501(c)(4) corporation, chartered in West Virginia and headquartered in Wheeling. A Board of Directors represented by citizens of the communities in which we serve governs the Health Plan. The plan holds HMO Certificates of Authority in both Ohio (43 counties) and West Virginia (all 55 counties).

Click [here](#) for a map of The Health Plan's current service area.

The Health Plan members are enrolled through Commercial products comprised of Commercial Employer Group offerings, Self-Funded Group plans, individual programs, and government programs including Medicare Advantage, Medicare Supplement, Dual-Eligible Special Needs Plan (DSNP), as well as WV Children's Health Insurance Program and Medicaid in West Virginia. The Health Plan provides or administers coverage to over 300,000 enrollees.

The Health Plan currently employs over 500 people throughout four office locations: Wheeling (corporate headquarters), Morgantown, Charleston, and Massillon, Ohio.

Our dedicated and specialized Clinical Services and Quality Assurance teams are committed to advancing the quality of care delivered by our providers and received by our members using the best available practices. We help people be healthy with programs and educational tools designed to promote healthier behaviors and positive health outcomes, not just for our members but also throughout our members' communities, because they are our communities too.

In addition to this manual and the training that accompanies it, The Health Plan customer service representatives are always available to assist in any way possible by calling 1.800.624.6961.



Provider Delivery Services

The Health Plan's Provider Delivery Services Division is comprised of three departments, each working to better serve the needs of our provider community. The departments include Provider Servicing, Provider Contracting and Provider Onboarding and Auditing.

The **Provider Servicing Department** consists of practice management consultants and provider operation specialists. The practice management consultants assist provider practices with education, quality incentives/reporting initiatives and identification of care delivery trends.

Practice management consultant contact information is located at healthplan.org, "For Providers, "Overview," "Meet the Provider Servicing Team."

The provider operation specialists are the provider's point of contact regarding claims questions, data related to best practice standards and provider portal concerns. The provider operation specialists also serve as an escalation point for the Customer Service Department.

The Health Plan's **Provider Contracting Department** is the point of contact for contracted providers and out-of-network negotiations for medically necessary services. They work to expand The Health Plan's network into new service areas. In addition, this department handles network adequacy analysis and reporting requirements.

The **Provider Onboarding and Auditing Department** consists of three teams: Provider Information Management, Provider Pricing and Provider Auditing.

The Provider Information Management team consists of credentialing, recredentialing and provider data quality. This team ensures that The Health Plan has a licensed and appropriately provisioned provider network to protect our members and provide care aligned with a provider's specialty and licensure. Provider data quality is tasked with the accuracy and completeness of our provider credentialing to allow for timely and accurate claims payment as well as accurate online and printed provider directories.

The Provider Pricing Team is accountable for receiving and entering new contracted rates, fee schedules from THP's government programs and the WV Public Employees Insurance Agency (PEIA).

The Provider Auditing Team will design and implement a division-wide auditing program to assure quality, accuracy and productivity across the division.

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, THP's secure platform is available 24 hours a day, seven days a week to verify member eligibility, benefits, and claim status inquiry.



Provider Quick Reference Guide

Our dedicated and friendly staff at The Health Plan are here to assist you when issues, questions or concerns arise. We've compiled a quick reference guide that lists important contacts that are most relevant for our providers.

To reach any department, call THP's main number: 1.800.624.6961

See below for contact information if you know the department that you would like to reach.

Customer Services – Assistance with Benefits, Eligibility, Pre-Authorization and Claims

| | |
|---|---|
| Customer Service – Fully Funded (including Commercial) | 1.888.847.7902 |
| Customer Service – Self-Funded | 1.888.816.3096 (Except Zappos) 1.877.794.7153 (Zappos) |
| Customer Service - Medicare | 1.877.847.7907 |
| Customer Service – Mountain Health Trust including WV Medicaid and WV Children's Health Insurance Program (WVCHIP) | 1.888.613.8385 |
| Behavioral Health (24/7) | 1.877.221.9295 |
| Coordination of Benefits (COB) | 1.800.624.6961, ext. 7903 |
| Electronic Data Interchange (EDI) Support | 740.699.6248 |
| eviCore healthcare | 1.877.791.4101 |
| NantHealth/Navinet Support | 1.888.482.8057 |
| Palladian Health | 1.877.244.8514 |
| Physician Access Line (24/7) | 1.866.687.7347 |
| Provider Information | Go to healthplan.org , "For Providers" |
| Urgent or Emergent Admissions (24/7) | 1.800.304.9101 |

Fax Numbers

| | |
|--|----------------|
| Behavioral Health | 1.866.616.6255 |
| Medical Records | 740.699.6163 |
| Palladian Health | 1.844.681.1205 |
| Provider Data Quality | 740.699.6169 |
| Submit Clinical Information for Review | 1.888.329.8471 |



| Email Contacts | |
|-----------------------------|--|
| Behavioral Health | behavioralhealthdocuments@healthplan.org |
| EDI | Hpecs@healthplan.org |
| eviCore healthcare | clientservices@evicore.com |
| Helpful Links | |
| eviCore healthcare | evicore.com |
| NaviNet | navinet.navimedix.com |
| Palladian Health | portal.palladianhealth.com |
| THP Corporate Website | healthplan.org |
| THP Provider Secure Website | myplan.healthplan.org |
| Provider Search | findadoc.healthplan.org/ |

Section 2

Physician Availability





Physician Availability

At The Health Plan (THP), we value our strong relationships with the communities we serve. Central to our core values is a commitment to advancing the quality of care delivered to our members.

This section of the manual includes general provider responsibilities, both for primary care physicians and specialists.

THP members enrolled in the HMO and POS products are required to select a primary care physician (PCP), who acts as the coordinator of care for the patient. Members must contact their PCP prior to making appointments with specialty providers. Upon assessment of the patient needs, the PCP may find it appropriate to refer the patient to other participating specialty providers.

THP contracts with providers in order to obtain quality care at an affordable price. This enables us to offer affordable health insurance premiums to our members. All services that can be properly performed by plan providers must be referred in-plan. Services that are not available through this in-plan network require prior authorization via an out-of-plan referral.

To provide better access to services, THP has established contracts with out-of-plan providers. This is known as the tertiary network. Should a member of The Health Plan require specialty of care or services not available through the in-plan network of providers, then his/her physician will refer him/her to one of the participating tertiary providers. These are still considered out-of-plan referrals requiring prior authorization.



Primary Care Physician Responsibilities:

- Maintain continuity of enrollee's health care by serving as the primary care provider
- Provide access twenty-four (24) hours a day, seven (7) days a week
- Make referrals for specialty care and other medically necessary covered services, both in-network and out-of-network, consistent with THP's utilization management policies
- Maintain a current medical record for the enrollee, including documentation of all services provided by the PCP, as well as specialty or referral services
- Adhere to EPSDT Periodicity Schedule for enrollees under age twenty-one (21)
- Follow THP's established procedures for coordination of in-network and out-of-network services for Medicaid enrollees
- Follow THP's access standards as described in The Health Plan Practice Guidelines and Standards

Important Information about Primary Care Physician Coverage Service

In an effort to control the high cost of emergency room (ER) utilization and to reduce the unnecessary denial of ER claims, this is a reminder of the physician's role as governed by his/her physician agreement. Physicians need to provide or arrange for service 24 hours a day, seven days per week. The physician should list one to two **participating** THP physicians as backups. The physician or designated backup(s) are to be available by phone or answering service. Answering machines should contain an appropriate message.

In cases of emergency (except for life endangering situations), The Health Plan members are instructed to call their primary care physician (PCP). If unable to reach their PCP, they are instructed to call The Health Plan 24-hour emergency number at **1.800.624.6961** for their physician's backups or for further assistance.



Primary Care Physician Guidelines

1. You will be listed on THPs's provider directory under primary care physicians (PCP)
2. If you have a medical subspecialty, you may also be listed under a second category for your specialty
3. If you wish to change to a different category on the provider lists, you must make a request in writing to Provider Delivery Services at providersupport@healthplan.org or by mail to Attention: Provider Delivery Services, 1110 Main Street, Wheeling, WV 26003
4. If you wish to be listed as NOT ACCEPTING NEW PATIENTS, you must meet the required minimum and make a written request to Provider Delivery Services.
5. Patient Roster:
 - The PCP patient roster can be obtained at any time through our secure provider portal, available at myplan.healthplan.org. The member information is updated every 24 hours, seven days a week. Be sure to cross-reference the member ID number, date of birth, and name that appears on your roster with the information in your member's chart to ensure that they are the same people. Please refer to the "Roster" folder on the left-hand side of your screen after logging onto the provider secure portal to obtain your member roster.
 - You will only have access to patients who have listed you as their PCP. It is important to review your roster. If you have patients who have been attributed to your practice, you should contact them to request that they become established with your practice. If they were assigned in error, report this to Provider Delivery Services and we will have Customer Service contact the member for reassignment.
 - Once you have obtained your roster, it should be checked for patients who:
 - May be listed but have never been seen, AND
 - Patients who are seen regularly but do not appear on the roster.
 - The roster should also be checked before patient appointments.
 - If you want the member to choose you as their PCP, please ask the member to call The Health Plan at the phone number on the back of their ID card while in your office. Members may change their PCP once per month.
 - If you want a patient removed from your roster, you must submit a request in writing to your Practice Management Consultant (refer to <https://www.healthplan.org/providers/overview/meet-provider-servicing-team> for your consultant's contact information) stating the reason for the request. You may make such a request in the following situations:
 - Noncompliance concerning the physician's orders
 - When a member has been seeing another PCP on a regular basis
 - When a member has been referred by another PCP on a regular basis
 - When a distinct personality clash exists

You will receive a response from THP and the member will receive a letter from The Health Plan confirming they choose another PCP.



PCPs Encouraged to Screen for Behavioral Health Needs

The primary care setting is one of the key points of access to screening, assessment, early intervention, referral, and treatment of behavioral health needs. The PCP is often the first to encounter a member with a mental health or substance abuse need and is in the unique position to assess the patient, utilize brief screening tools and to treat or refer members as needed.

The Health Plan encourages PCPs to use appropriate screening tools to assess members for behavioral health needs. Screenings should be provided to people of all ages, even the young and the elderly. If you need assistance with referral to a behavioral health specialist contact The Health Plan's Clinical Services Department at 1.800.624.6961, ext. 7644 for assistance.

The Health Plan also encourages the sharing of information between primary care and behavioral health providers. For your convenience, the "Authorization to Disclose Health Information to Primary Care Physician and Continuity of Care" form is available on the website at myplan.healthplan.org, "Forms," "Behavioral Health Forms."

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Substance use disorder (SUD) is a widespread problem. Many times, the PCP is often the first to encounter a member with alcohol or other substance use disorder issues.

The Health Plan suggests a few points for PCPs to consider when encountering patients who may be experiencing problems with substance use disorders.

What PCPs Can Do:

- Carefully ask about SUDs and screen for problem use.
- Make sure the diagnosis is listed in the patient chart and on your claims.
- Follow-up with the patient. Schedule a follow-up appointment or schedule an appointment with a qualified behavioral health clinician. Make sure that a substance use disorder diagnosis is included on each follow-up visit. Patients may want to minimize their use of a substance, so persistence is required in raising the topic and keeping it at the forefront of a patient's care.
- Encourage the patient to follow through. Express interest in his/her progress.
- Make a clear statement about needing to cut down if use is problematic. Give advice.
- Consult The Health Plan guidelines for the treatment of patients with substance use disorders that includes various screening tools.

PCPs should be mindful that SUDs can occur with other behavioral health problems such as major depression or anxiety disorder, which can make treating SUDs or diagnosing a behavioral health disorder more difficult. In these instances a referral to a behavioral health provider is prudent. PCPs wishing to refer a patient for behavioral health services or to facilitate coordination of services may call Clinical Services at 1.800.624.6961, ext. 7644 for assistance. Additional resources on substance use disorders can be found at nida.nih.gov.



Secondary Care Physician Guidelines

Members may select a secondary care physician (SCP).

1. The following provider specialties can be selected as a secondary care provider (SCP):
 - OB/GYN
 - Endocrinologist
 - Oncologist
 - Nephrologist

A SCP will be listed on The Health Plan's provider list with two categories: SCP and specialist. Those specialists listed as a primary or secondary care physician may require a referral if the specialist is not listed as the member's PCP or SCP.

2. If the member has selected you as a SCP, they pay the PCP copay in most cases, depending on the plan's summary plan description (SPD)
3. If you want to change to a different category on the provider list, you must make a request in writing to Provider Delivery Services at providersupport@healthplan.org or by mail to Attention: Provider Delivery Services, 1110 Main Street, Wheeling, WV 26003.
4. If you want to be listed as NOT ACCEPTING NEW PATIENTS, you must meet the minimum requirements and submit a written request to Provider Delivery Services.
5. Patient Roster:
 - SCP patient rosters can be obtained at any time through our secure provider portal, available at myplan.healthplan.org. Be sure to cross-reference the member ID number, date of birth, and name that appears on your roster with the information in your member's chart to ensure that they are the same people. Please refer to the "Roster" folder on the left-hand side of your screen after logging onto the provider secure portal for obtaining your member roster.
 - You will only have access to patients who have listed you as their SCP.
 - Once you have obtained your roster, it should be checked for patients who:
 - May be listed but have never been seen, AND
 - Patients who are seen regularly but do not appear on the roster.
 - The roster should also be checked before patient appointments.
 - If you want the member to choose you as their SCP, please ask the member to call The Health Plan at the number on the back of their ID card from your office. Members may change their SCP once per month,
 - If you want a patient removed from your roster, you must submit a request in writing to your Practice Management Consultant (refer to <https://www.healthplan.org/providers/overview/meet-provider-servicing-team> for your consultant's contact information) stating the reason for the request. You may make such a request in the following situations:
 1. Noncompliance concerning the physician's orders.
 2. When a distinct personality clash exists.

You will receive a response from THP and the member will receive a letter from THP confirming they choose another SCP. In that case, you will receive a copy of The Health Plan letter to the member.



SCP may provide referrals **only in cases** where the referral is related to care pertaining to his/her specialty. If you are not listed as the member's SCP, you are considered a specialist and a referral from the PCP is required.

Specialist Guidelines

1. You will be listed in The Health Plan provider directory under SPECIALISTS THAT MAY REQUIRE REFERRALS. The PCP is the coordinator of all medical care for the member, and needs to coordinate referrals to specialists. Self-Insured (ASO) members may still require phone-in referrals to a specialist.
2. If you wish to change to a different category in the provider directory, you must make a request in writing to Provider Delivery Services at providersupport@healthplan.org or by mail to Attention: Provider Delivery Services, 1110 Main Street, Wheeling, WV 26003. Your request will be reviewed in accordance with The Health Plan's credentialing guidelines to assure you meet qualifications required for a specific category.
3. Except in situations requiring emergency treatment, specialists shall only treat members upon referral from a PCP or a SCP.
4. Except in situations requiring emergency treatment, *specialists must submit a report to the appropriate PCP or SCP* concerning the proposed plan of specialty treatment, including possible hospitalization or surgery, as soon as possible after examination of a member.
5. Specialists should contact the PCP to arrange referrals to another physician. *Specialist-to-specialist referrals are not generally permitted.* In emergencies, a specialist to whom a member has been referred may refer that member to another specialist only when the referral is related to care his or her specialty, i.e., specialized surgery and/or care requiring tertiary services. THP recommends, however, that the specialist communicate with the PCP regarding the need for the referral. This may be done after the fact in instances where the emergency may require immediate action.
6. Specialists will send a copy of the member's treatment record to the appropriate PCP or SCP.



Physician Care of Self or Family

Based on recommendations from the American Medical Association (AMA), The Health Plan upholds that practitioners should not treat themselves or their immediate family members, or members of their household. Accordingly, The Health Plan benefit plans DO NOT permit payment to a provider for treating their family members.

The following degrees for relationship are included within the definition of immediate relative.

- Husband and wife
- Natural or adoptive parent, child, and sibling
- Stepparent, stepchild, stepbrother, and stepsister
- Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law
- Grandparent and grandchild
- Spouse of grandparent and grandchild

EMERGENCIES: In the case of medical emergencies, a THP practitioner can provide care until a qualified practitioner is available.

ORDERS (written or verbal): The Health Plan practitioners shall not write orders or dictate verbal orders for themselves or a member of their immediate family.

PRESCRIPTIONS: The Health Plan practitioners shall not write prescriptions for themselves or members of their immediate family.

PCP ASSIGNMENT: The Health Plan practitioners shall not be permitted to act as primary care physician for themselves or members of their immediate family.

Section 3

Member Benefits





Member Benefits

The Health Plan (THP) member handbook is the primary source of information regarding The Health Plan member benefits.

Office Copayment

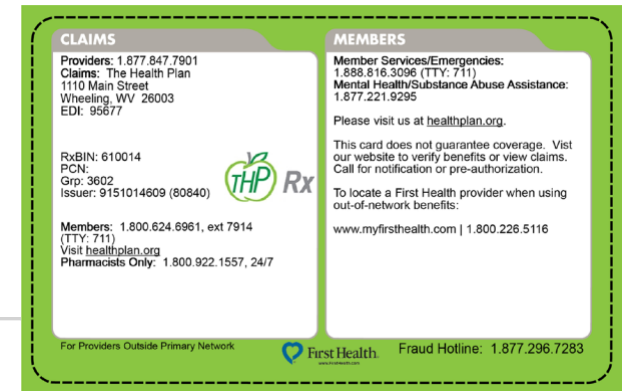
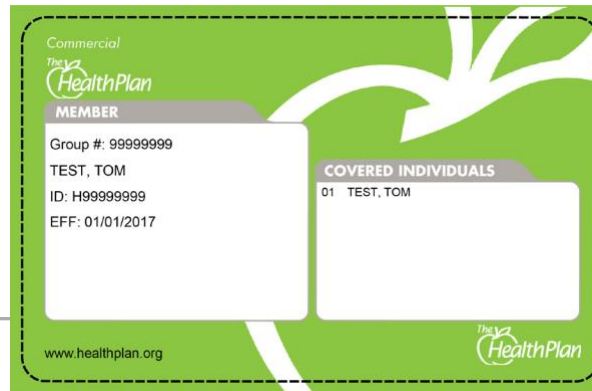
Members are subject to the copayment of the benefit plan chosen. The copay should be collected at the time of service, unless other arrangements have been made. Waiving copays is a provider contract violation.

Product Matrix

The following product matrix lists all the products offered by The Health Plan. This matrix identifies the basic plan design of each product and includes a sample ID card.



PRODUCT MATRIX



SAMPLE ID CARD FRONT/BACK

| | Member selects Primary Care Physician (PCP) | Referrals required for Specialty Care | Member has Open Access to Secondary Care Provider (OB/GYN, Endocrinology, Oncology & Nephrology) | Member has Mental Health Open Access | Member has Out-of-Network Benefits |
|------------------------------|---|--|--|--|---|
| COMMERCIAL | | | | | |
| Fully Funded HMO | YES | YES. PCP must coordinate all specialty care and document all referrals in the patient's chart. Prior authorization must be submitted to The Health Plan for any tertiary or out-of-network care. | Yes, for in-network secondary care physician when selected. | YES. Refer to Directory for appropriate providers. | NO |
| Fully Insured POS | YES | YES. PCP must coordinate all specialty care and document all referrals in the patient's chart. Prior authorization must be submitted to The Health Plan for any tertiary or out-of-network care. | Yes, for in-network secondary care physician when selected. | YES. Refer to Directory for appropriate providers. | YES |
| Fully Insured PPO | NO | NO. Member may self-refer to any network specialist to receive in-network benefits. | Yes, for in-network secondary care physician when selected. | YES. Refer to Directory for appropriate providers. | YES |
| SELF-FUNDED | | | | | |
| Self-Funded HMO, PPO, POS | PPO: NO HMO, POS: YES | PPO: NO. HMO, POS: YES. Services requiring referral/prior authorization may differ by plan sponsor. Contact The Health Plan to confirm benefits. | Determined by specific employer benefits. | Determined by specific employer benefits. | Determined by specific employer benefits. |
| MOUNTAIN HEALTH TRUST | | | | | |
| WV Medicaid WVHB/SSI/WVCHIP | YES | YES | Yes, for in-network secondary care physician when selected. | YES. Refer to Directory for appropriate providers. | NO |
| MEDICARE | | | | | |
| SecureCare HMO* | YES | YES. PCP must coordinate all specialty care and document all referrals in the patient's chart. Prior authorization must be submitted to The Health Plan for any tertiary or out-of-network care. | Yes, for in-network secondary care physician when selected. | YES. Refer to Directory for appropriate providers. | NO |
| SecureCare DSNP | YES | YES. PCP must coordinate all specialty care and document all referrals in the patient's chart. Prior authorization must be submitted to The Health Plan for any tertiary or out-of-network care. | Yes, for in-network secondary care physician when selected. | YES. Refer to Directory for appropriate providers. | NO |
| SecureChoice PPO | NO | NO | YES | YES. Refer to Directory for appropriate providers. | YES |
| Medicare Supplement | NO | NO. Member may self-refer to any specialist who accepts Medicare. | YES | YES | YES. Any provider who accepts Medicare. |

For verification of eligibility or benefit information specific to a particular member, go to navinet.navimedix.com. If you require assistance with registering for access to this secure website, please call 1.800.624.6961, ext. 6248.

* Includes WVU Medicine – The Health Plan SecureCare (HMO)



Commercial HMO Plans

Commercial health maintenance organization (HMO) plans are plans that are fully insured by a Health Insuring Corporation (HIC). Employer groups contract with The Health Plan to provide a health insurance benefit plan and pay a monthly premium to cover eligible employees. The Health Plan is responsible for providing the benefit package, administering all aspects of the plan and assuming the risk for paying for all covered services. These plans require a member to choose a primary care physician (PCP), and the member must be referred by their PCP and follow precertification guidelines for procedures, diagnostic testing, outpatient surgical procedures, and inpatient admissions. Members do not have out-of-network benefits unless authorized by the plan.

HMO benefit plans generally have copays for:

- Primary and specialty care physician office visits
- Emergency room services
- Urgent care
- Outpatient mental health
- Physical, occupational, and speech therapy
- Durable medical equipment
- Prescription drugs

Members may have a deductible and co-insurance associated with their benefit plan, as well as cost sharing for laboratory and x-rays, not associated with preventive services, depending on the plan.



Commercial Point-of-Service (POS) Plans

Commercial point-of-service (POS) plans are fully insured by a Health Insuring Corporation (HIC). Employer groups, with a minimum size of two employees, contract with The Health Plan to provide a health insurance benefit plan and pay a monthly premium to cover eligible employees.

POS plans are designed to allow members the freedom to choose between having their health care managed or arranged by their PCP as an in-plan option, or having their health care arranged as an out-of-plan option. The plan provides the benefit package giving the employer the option to choose from a variety of deductibles and copay plans. These plans require a member to choose a PCP, obtain a referral for specialty physician services, and follow precertification guidelines for procedures, diagnostic testing, outpatient surgical procedures, and inpatient admissions.

Members have out-of-plan option benefits and may choose to access services outside The Health Plan network at an increase in their out-of-pocket expense for deductibles, copays, and co-insurance amounts.

POS benefit plans generally have copays for:

- Primary and specialty care physician office visits
- Emergency room services
- Urgent care
- Outpatient mental health
- Physical, occupational, and speech therapy
- Durable medical equipment
- BioTech drugs

Additionally, members are responsible for deductibles and co-insurance amounts associated with their plan benefit.



Commercial Preferred Provider Organization (PPO) Plans

Commercial preferred provider organization (PPO) plans are fully insured by a Health Insuring Corporation (HIC). Employers contract with The Health Plan to provide a health insurance benefit plan and pre-pay a monthly premium to cover eligible employees. Members who are covered under the PPO plan generally are not required to select a primary care physician (PCP) or obtain a referral for specialty physician services. All prior authorization guidelines for procedures, diagnostic testing, outpatient surgical procedures, and inpatient admission apply. By utilizing The Health Plan in-plan or tertiary network, members receive a higher level of benefits. Members who utilize out-of-network providers or fail to preauthorize a service will have increased out-of-pocket expenses for deductibles, copays, and co-insurance amounts.

PPO benefit plans generally have copays for:

- Primary and specialty care physician office visits
- Emergency room services
- Urgent care
- Outpatient mental health benefits
- Physical, occupational, and speech therapy
- Durable medical equipment
- BioTech drugs

Additionally, members are responsible for deductibles and co-insurance amounts associated with their benefit plan.



Sample Commercial ID Cards

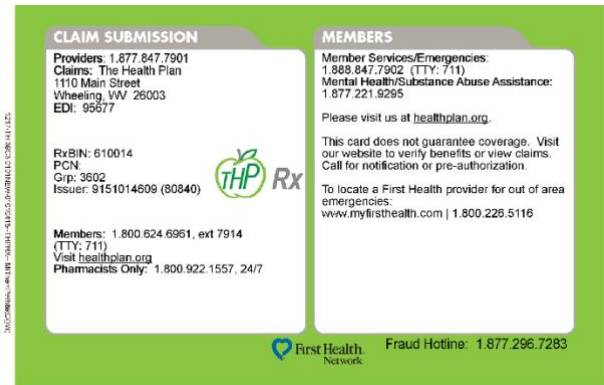
This card is issued to members enrolled in a Commercial HMO or PPO plan. This includes WV State employees who are covered by the Public Employees Insurance Agency (PEIA).

HMO Sample ID Card

FRONT



BACK

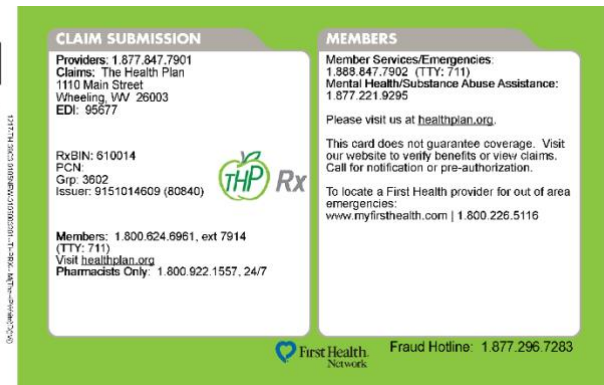


POS Sample ID Card

FRONT



BACK

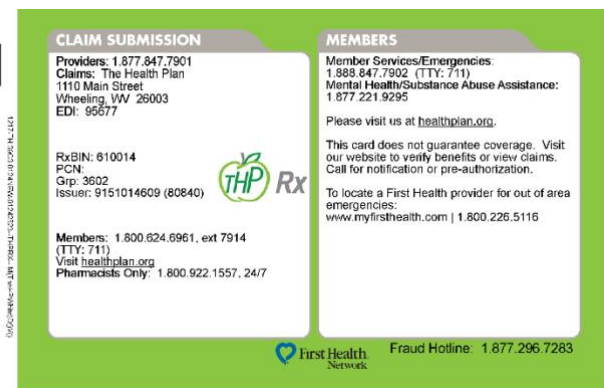


PPO Sample ID Card

FRONT



BACK





Administrative Services Only (ASO) Self-Funded Employer Groups

Many employers choose to pay claims as they are incurred, rather than pay a prepaid monthly premium for their employee's medical benefits. The Health Plan offers administrative services only (ASO) plans to assist these employers with administering their benefit plan. The plan offers them a contracted network of providers, utilization management services, medical management, prescription plans, customer service and claims processing. These plans are most often designed by the employer group and administered by The Health Plan. ASO plan benefits, copays, deductibles, and ID cards may vary from the standard insured plans offered by The Health Plan.

Sample Self-Funded ID Cards

This card is issued to members who are enrolled in a Self-Funded plan. The company name will differ on these cards (as shown in the red box below).

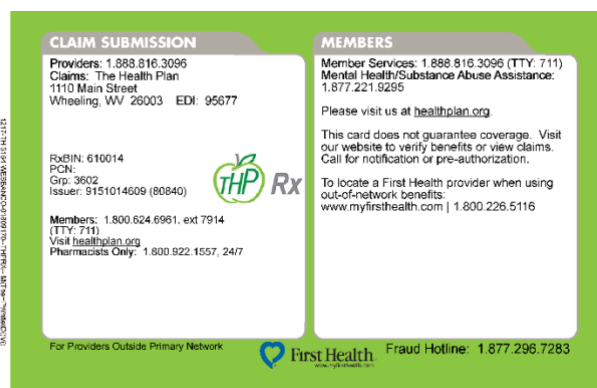
Note: Services requiring referral/ prior authorization may differ by plan. Contact The Health Plan to confirm benefits.

ASO Sample ID Card

FRONT



BACK

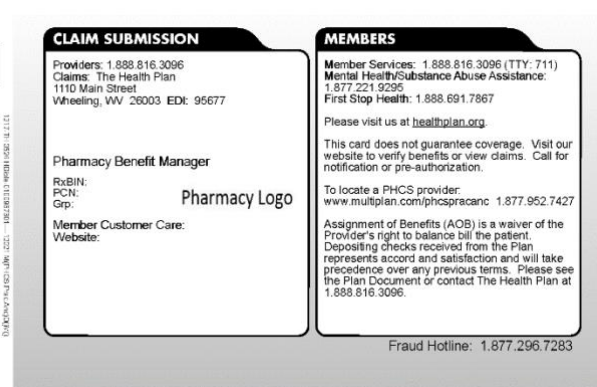


ASO Reference Based Pricing (RBP) Sample ID Card

FRONT



BACK





SecureCare HMO Medicare Advantage Plan

The Health Plan has entered into a contract with the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers the Medicare program. Under this contract, CMS makes a monthly payment to The Health Plan for each Medicare beneficiary who enrolls in our Plan. This contract requires The Health Plan to provide comprehensive health services to persons who are entitled to Medicare benefits and who choose to enroll in The Health Plan. The Health Plan receives a set rate for each member plus any enrollee premium.

Medicare Advantage benefit plans generally have copays for:

- Primary and specialty care physician office visits
- Inpatient admissions
- Skilled nursing home services
- Emergency room services
- Urgent care
- Outpatient mental health visits
- Physical, occupational, and speech therapy
- Biological drugs
- Durable medical equipment

Members may have a deductible and co-insurance associated with their benefit plan, as well as cost sharing for laboratory and x-rays, not associated with preventive services.

SecureChoice PPO Medicare Advantage Plan

SecureChoice PPO is The Health Plan's Medicare Advantage preferred provider organization (PPO) option. SecureChoice PPO members are not required to select a primary care physician (PCP) and referrals to specialists are not required. The Health Plan prior authorization requirements apply.

The SecureChoice PPO plan provides benefits at an "in-network" level from The Health Plan's extensive network of participating providers.

The SecureChoice PPO plan also provides benefits to SecureChoice PPO members at an "out-of-network" level from any Medicare provider of choice at an additional out-of-pocket expense to the member.

The benefits for SecureChoice PPO members are identical to traditional Medicare benefits in addition to enhanced benefits that are offered by The Health Plan.

PPO benefit plans generally have copays for:

- Primary and specialty care physician office visits
- Emergency room services
- Urgent care
- Outpatient mental health benefits
- Physical, occupational, and speech therapy
- Durable medical equipment
- BioTech drugs

Additionally, members are responsible for deductibles and co-insurance amounts associated with their benefit plan.



D-SNP Program (Medicare Advantage Special Needs Plan)

Effective January 1, 2014, The Health Plan began a Medicare Special Needs Plan (SNP) for those members who have a chronic condition. The special needs population are those recipients who qualify for both Medicare and Medicaid. These Dual Eligible Special Needs Population (D-SNP) members are individuals who are entitled to Medicare and are also eligible for some level of assistance from their state Medicaid program.

SNP members will select a primary care physician (PCP) and a THP case manager will be assigned to the member.

Provider Reimbursement and Billing

The provider will bill The Health Plan for medically appropriate covered services provided to the DSNP member. The Health Plan will reimburse the provider for services rendered according to the member's benefit plan, less any copays, co-insurance, or deductible amounts. The provider will then be eligible to submit any balance associated with the copays, co-insurance, and deductible directly to West Virginia or Ohio Medicaid program.

To obtain referrals or eligibility information please call our Customer Service Department at 1.877.847.7907.

Federal law prohibits Medicare providers from collecting Medicare Part A and Medicare Part B deductibles, co-insurance, or copayments from those enrolled in the dual-eligible program. This program exempts individuals from Medicare cost-sharing liability. Medicare providers must accept the Medicare payment and Medicaid payment (if any) as payment in full for services rendered to an eligible member. Providers who bill a qualified dual-eligible member for amounts above the Medicare and Medicaid payments (even when Medicaid pays nothing) are subject to sanctions. See Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the Balanced Budget Act of 1997. This section of the Act is available at ssa.gov/OP_Home/ssact/title19/1902.htm.

Providers may not discriminate by refusing to serve enrollees because they receive assistance with Medicare cost-sharing from a state Medicaid program.

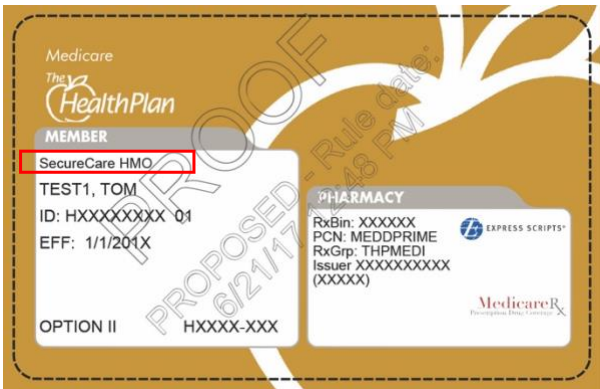
If a provider who is balance billing or refusing to take DSNP patients is referred to us, The Health Plan will send Medicare MLN Matters documents to the provider and the training documented. This policy is included in Section 4 of the Provider Procedural Manual and published periodically in our quarterly ProviderFocus newsletter.



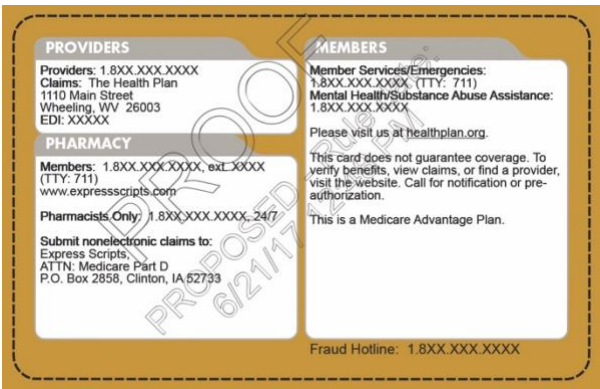
Sample Medicare ID Cards

This card is issued to Medicare members who are enrolled in our HMO, PPO, or D-SNP plans. The specific plan will be indicated on the front of their ID card (as shown in the red box below).

FRONT



BACK





Mountain Health Trust (MHT) Program

The MHT program includes members enrolled in WV Medicaid's Temporary Assistance for Needy Families (TANF), WV Health Bridge (Expansion), Supplemental Security Insurance (SSI) and WV Children's Health Insurance Program (WVCHIP). The plans offered under MHT are fully insured managed care plans offered to eligible residents of West Virginia. Each plan requires a member to select a primary care physician (PCP), obtain a referral for specialty physician services, and follow prior authorization guidelines for procedures, diagnostic testing, outpatient surgical procedures, and inpatient admissions. Members do not have out-of-network benefits unless prior authorization is given by the plan.



Under the MHT program, the state of West Virginia determines eligibility and enrollment through a broker hired by the state of West Virginia for enrollment services. Once the member selects The Health Plan, we are notified electronically of enrollment. At that time, a packet of information is sent to the member, along with an ID card from The Health Plan. Members have one identification card issued by The Health Plan. Upon request, THP will reissue an ID card when it is lost or if a member changes his/her PCP.

The date appearing on The Health Plan ID card is the actual date the card was printed and not the effective date of coverage. The effective date of coverage is always the first of the month, except for a newborn.



You may contact The Health Plan Customer Service Department at 1.888.613.8385 to check eligibility or if you have any question regarding the MHT program. Eligibility, benefits, and claims status are available through our secure provider portal.



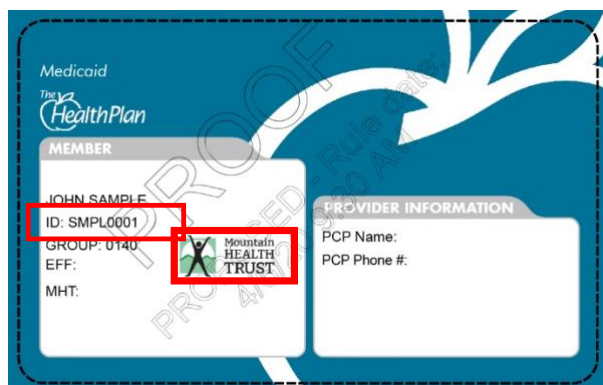
Sample WV Medicaid ID Card

This card is issued to WV Medicaid members who are enrolled in our MHT () or WV Health Bridge plans (). The specific plan and group number that a member is enrolled in will be indicated on the front of their ID card (as seen in the red boxes below).

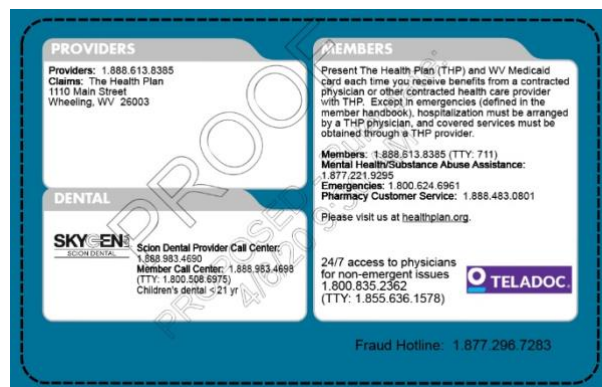
Take note of the member's group number:

- MHT plan (): 0140 (TANF) or 0142 (SSI)
- WV Health Bridge plan (): 0141

FRONT



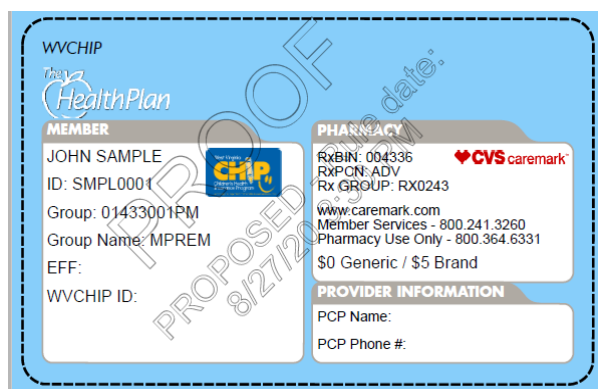
BACK



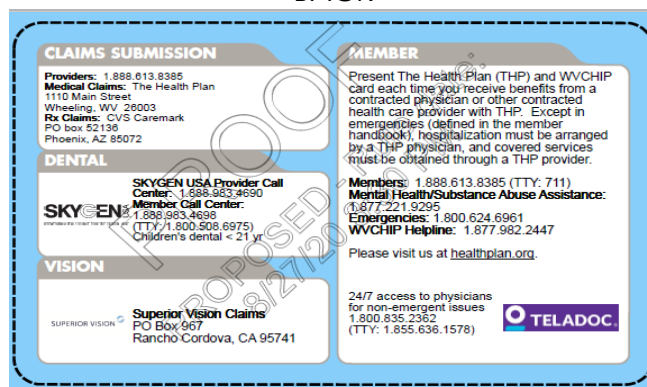
Sample WVCHIP ID Card

This card is issued to WVCHIP members. The member's group number is 0143. All pertinent billing information is on the card, including the members' THP ID number and WVCHIP ID number.

FRONT



BACK





Vision Service Benefit

Members enrolled through The Health Plan Commercial and Medicare programs may also have vision benefits. Superior Vision administers vision benefits for Commercial members and Medicare members. Please refer to resources available through Superior Vision for information on benefits and coverage under these vision plans.

The Health Plan offers benefit riders for vision benefits administered through Superior Vision for commercial, Mountain Health Trust (MHT) and Medicare members. Providers must be a participating provider with a Superior Vision provider to be eligible to offer covered vision services. You will need to verify vision coverage through Superior Vision.

Please refer to **Section 5** for additional information on vision benefits for MHT members.

Superior Vision (superiorvision.com)

Monday – Friday 8 a.m. to 9 p.m. EST

1.844.353.2900

Please note: Members are entitled to vision benefits only under this separate vision service program.

Members may require ophthalmologic medical services in conjunction with a medical condition. These medical services must be offered through a contracted ophthalmologist or optometrist with The Health Plan. A referral from the primary care physician (PCP) may be required for the member to obtain medical services from an ophthalmologist or optometrist.

Billing for Medical Eye Exams with a Vision Screening

In most situations, a vision screening (CPT 92015 Determination of Refractive State) is considered non-covered under a medical benefit plan but is often covered by a vision benefit plan. When there is the need to provide a vision screening as part of a medical exam, the following billing guidelines will assist you in obtaining appropriate reimbursement for the vision screening if there is a benefit that is available through The Health Plan's vision benefit vendors, provided you are a participating provider. Please note for Medicare members 92015 is a non-covered service when billed separately.

Billing Procedures

The visit is billed to The Health Plan on the appropriate CMS 1500 form with the following codes:

| | | |
|--------------------------------------|-----------|---|
| 92002, 92004, 92012, or 92014 | | Eye exam, new or established patient |
| 92015 | vs | Determination of refractive state |

After The Health Plan has made payment for the exam and denied the refraction as non-covered, you can then submit the visit code and the 92015 – Determination of Refractive State – to The Health Plan's vision provider (as long as you are a contracted provider) for payment of the refraction.

You must include our payment voucher (with the page that shows the explanation of the denial codes) when submitting to Superior Vision for the remaining portion.



Vision provider will coordinate benefits with The Health Plan and pay only the refraction, which is still due when a benefit is available to cover the refraction. If the member has a vision benefit through some other plan that is not associated with The Health Plan, you may also submit a claim for the refraction to that plan in the same manner and they will adjudicate the claim according to their plan guidelines.

The Health Plan encourages our **diabetic members** to see an in-plan **ophthalmologist** or **optometrist** for an annual dilated retinal exam (excludes self-funded ASO participants.) If a **92015-Determination of Refractive State** is also completed during the visit, the following billing procedures apply.

- Without a referral and with a waiver of the associated office copayment.

Once The Health Plan has made payment, you can then submit the visit code and the 92015-Determination of Refractive State to the appropriate vision plan, for payment of the refraction. You must include our payment voucher when submitting to Superior Vision for the remaining portion. Superior Vision will coordinate benefits with The Health Plan and pay only the fraction which is still due.

| The Health Plan | | | | | | | | | | | | | |
|--|---------------|-----------|-------------------|----------------------------------|------------|----------------|--------|----------------------|-------|-----|--------|-----|-------|
| PROVIDER REIMBURSEMENT VOUCHER | | | | | | | | | | | | | |
| EYE CARE SPECIALIST NAME | | | | PROVIDER NO: QG00000 (000000) | | | | TAX ID: 000000000 | | | | | |
| CLAIMS PAID | | | | *** COMMERCIAL *** | | | | CHECK NUMBER: 888888 | | | | | |
| CLAIM NO | ACCOUNT NO | HID NO | MEMBER NAME | MEMBER RESPONSIBLE | ADMIN | ADJ | | | | | | | |
| DATE SRV | CPT MODIFIERS | UNT | BILLED | ALLOWED | DISALLOW | COPAY | CO-INS | DEDUCT | OTHER | COB | PAID | W/H | FEE |
| DSCNT | CD | | | | | | | | | | | | |
| 201120112011 | 155555-55 | H01010101 | SUNSHINE, SALLY A | Q111111 | 1111111111 | JANE A. DOE OD | | | | | | | |
| 11/04/2011 | 92004 | 1 | 165.00 | 147.69 | 17.31 | 15.00 | .00 | .00 | .00 | .00 | 132.69 | .00 | .00 L |
| 11/04/2011 | 92015 | 1 | 32.00 | .00 | .00 | .00 | .00 | .00 | 32.00 | .00 | .00 | .00 | NV |
| TOTAL | | 1 | 197.02 | 179.69 | 17.33 | 15.00 | .00 | .00 | 32.00 | .00 | 132.69 | .00 | .00 |
| ***Could also be denied VI.*** (see below) | | | | | | | | | | | | | |

Include the page of the voucher that has explanation of the denial codes when submitting to VSP or Superior Vision.

| The Health Plan | |
|--|---|
| PROVIDER REIMBURSEMENT VOUCHER | |
| EYE CARE SPECIALIST NAME | PROVIDER NO: QG00000 (000000) |
| TAX ID: 000000000 | |
| ADJUSTMENT CODE DESCRIPTION | |
| L | = BILLED AMOUNT EXCEEDS THE MAXIMUM ALLOWABLE |
| NV | = VISUAL SERVICES ARE A NON-COVERED BENEFIT - PATIENT RESPONSIBLE |
| [We deny NV when our member does NOT have vision coverage through The Health Plan; however, if member does have vision coverage through another carrier, please bill that carrier for this service.] | |
| VI | = VISION INSURANCE - CLAIM NOT COVERED BY THIS PAYER/CONTRACTOR |
| [VSP is the Commercial vendor and Superior Vision is the vendor for Medicaid and Medicare] | |
| ADJUSTMENT CODE DESCRIPTION | |
| # | = CLAIM HAS CLEARED PROCESSING EDITS |
| D109 | = Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor. |
| 204 | = This service/equipment/drug is not covered under the patients current benefit plan |
| 97 | = Payment is included in the allowance for another service/procedure. |
| 3 | = Co-payment Amount |
| 45 | = Charges exceed your contracted/ legislated fee arrangement. |
| N418 | = Misrouted claim. See the payers claim submission instructions. |
| N538 | = A facility is responsible for payment to outside providers who furnish these services/supplies/drugs to its patients/residents. |



The Health Plan's Members' Rights and Responsibilities Statement

Statement of Members' Rights

- Members have the right to receive information regarding the plan. This includes information such as a summary of the plan's accreditation report and the plan's services, policies, benefits, limitations, practitioners and providers. Members have the right to information on member rights and responsibilities as well as any charges they may be responsible for. Members have the right to obtain evidence of medical credentials of a plan provider, (i.e. diplomas and board certifications). If a member needs assistance with any of the above, they may contact The Health Plan's Customer Service Department at 1.888.847.7902.
- Members can expect to receive courteous and personal attention and to be treated with dignity. Plan employees, providers and their staff will respect members' privacy.
- All information concerning The Health Plan member's medical history and enrollment file is confidential. The member has a right to approve or refuse the release of personal information by The Health Plan except when the release is required by law. The Health Plan assures that all patient information is held in the strictest confidence. All staff must adhere to The Health Plan confidentiality policy revised and adopted in November 1993. This statement acknowledges the confidential nature of the review work, includes an agreement to honor that confidentiality, and documents the consequences of failing to do so.
- The member's personal choice of a primary care physician (PCP) enables the member to participate in the management of his/her total health care needs, including the right to refuse care from a specific practitioner. Members of The Health Plan are encouraged to establish a relationship with their chosen PCP so that they can work together to maintain good health. Members of The Health Plan may change physicians once per calendar month if so desired (depending upon the availability of the chosen physician).
- The Health Plan members have the right to express their comments, opinions or complaints about The Health Plan or the care provided and to file a grievance for an administrative or medical complaint and hearing procedures without reprisal from The Health Plan. Members also have the right to have coverage denials reviewed by the appropriate medical professionals consistent with The Health Plan review procedures. Both informal and formal steps are available to members to resolve all complaints/grievances.
- The Health Plan members may participate in decision-making about their health care when possible and within the plan guidelines. Members have a right to discuss with providers, without limitations or restrictions being placed upon the providers, appropriate or medically necessary treatment options for their condition(s) regardless of cost or benefit coverage. However, this does not expand coverage by the plan. Members also have the right to formulate advance directives.
- The Health Plan members have the right to have a meaningful voice in the organization by expressing their suggestions and comments regarding their health plan coverage, policies, members' rights and responsibilities, and operations. Member's comments and opinions are received by The Health Plan through yearly member satisfaction surveys, telephone calls from our members, by email to: information@healthplan.org or through our [corporate website](#). Member's comments/opinions are also received through various departments at The Health Plan.



- Members have the right to full disclosure, from their health care provider, of any information relating to their medical condition or treatment plan. Members have the right to examine and offer corrections to their own medical records, in accordance with applicable federal and state laws. The plan will not release personal health information to an employer, or its designee, without a signed plan authorization form by the member. For information on obtaining medical records, contact The Health Plan Customer Service Department at 1.888.847.7902.

Statement of Members' Responsibilities

- A member must choose a PCP for each person listed on The Health Plan ID card. The member has a responsibility to maintain a relationship with a PCP, as the PCP will act as the coordinator for all his/her health care needs.
- A member must identify him/herself as a member of The Health Plan to avoid unnecessary errors; always carry their ID cards; and never permit anyone else to use their ID card.
- A member is asked, through outreach calls to new members, to read their member handbook and understand the benefits and procedures for receiving health care services. To assure maximum coverage, the member has a responsibility to follow the rules and to contact The Health Plan for assistance, if necessary.
- A member is required to notify The Health Plan of any changes in the following:
 1. Name, address, telephone number
 2. Number of dependents (marriage, divorce, newborns, etc.)
 3. Loss of an identification card
 4. Selection of a primary care physician
- Members are asked to be on time for appointments and to call the physician's office promptly if an appointment cannot be kept.
- Members must provide necessary information to the providers rendering care. Such information is necessary for the proper diagnosis and/or treatment of potential or existing conditions.
- Members must understand your health problems and participate in developing mutually agreed upon treatment goals, to the degree possible, and follow those instructions and guidelines given by the providers who deliver health care services.
- If members receive emergency care outside The Health Plan's service area, they are required to contact The Health Plan as soon as possible within 48 hours.
- Members must contact their PCP, secondary care physician, or OB/GYN **before** seeking any specialty physician/service.
- Members must provide The Health Plan with all relevant, correct information and pay The Health Plan any money owed according to coordination of benefits or subrogation policies.
- Members must make required copayments under the schedule of benefits.
- Members are asked to be courteous and respectful of The Health Plan employees, providers, and their staff.

Section 4

Medicare





SecureCare HMO Medicare Advantage Plan

The Health Plan has entered into a contract with the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers the Medicare program. Under this contract, CMS makes a monthly payment to The Health Plan for each Medicare beneficiary who enrolls in our plan. This contract requires The Health Plan to provide comprehensive health services to persons who are entitled to Medicare benefits and who choose to enroll in The Health Plan. The Health Plan receives a set rate for each member plus any enrollee premium.

Medicare Advantage benefit plans generally have copays for:

- Primary and specialty care physician office visits
- Inpatient admissions
- Skilled nursing home services
- Emergency room services
- Urgent care
- Outpatient mental health visits
- Physical, occupational, and speech therapy
- Biological drugs
- Durable medical equipment

In keeping with The Health Plan's mission, we have identified members' rights, along with their responsibilities, that are clearly indicated in the member's handbook.

The benefits for SecureCare HMO members are identical to traditional Medicare benefits. In addition, The Health Plan offers enhanced benefits for SecureCare members.

It is imperative that you are aware of these rights and responsibilities as a participating provider with The Health Plan. You are expected to assist our members by making them aware of their rights and by supporting these within your practice.

Please refer to this section of the manual for important information regarding CMS quality standards that you are required to meet when caring for Medicare Advantage enrollees. The Member Services Department is available to assist with any member issues that may arise at 1.877.847.7907.

SecureChoice PPO Medicare Advantage Plan

SecureChoice PPO is The Health Plan's Medicare Advantage preferred provider organization (PPO) option. SecureChoice PPO members are not required to select a primary care physician (PCP) and referrals to specialists are not required. The Health Plan prior authorization requirements do apply.

The SecureChoice PPO plan provides benefits at an "in-network" level from The Health Plan's extensive network of participating providers.

The SecureChoice PPO plan also provides benefits to SecureChoice PPO members at an "out-of-network" level from any Medicare provider of choice at an additional out-of-pocket expense to the member.

The benefits for SecureChoice PPO members are identical to traditional Medicare benefits. The Health Plan also offers enhanced benefits for SecureChoice members. As with the SecureChoice HMO plan, it is imperative that you are aware of these rights and responsibilities as a participating provider so that you may assist our members within your practice.



D-SNP Medicare Advantage Special Needs Plan

Effective January 1, 2014, The Health Plan began a Medicare Special Needs Plan (SNP) for those members who have a chronic condition. The special needs population are those recipients who qualify for both Medicare and Medicaid. These Dual Eligible Special Needs (D-SNP) members are individuals who are entitled to Medicare and are also eligible for some level of assistance from their state Medicaid program.

The Health Plan received approval as a contracted MA-PD (Medicare Advantage Prescription Drug) plan that offers a SNP program by completing a Model of Care (MOC) for Centers for Medicare and Medicaid Services (CMS). This approval applies to the Dual-Eligible Special Needs Plan (D-SNP).

The Health Plan has developed the MOC to provide comprehensive care management to members enrolled in the D-SNP. The Health Plan's MOC is a written document describing measurable goals of the program. The Health Plan staff structure, care management roles and interdisciplinary care team (ICT) use clinical practice guidelines and protocols to provide yearly training for personnel and our providers. The care management team uses a health risk assessment tool to collect information about our members to develop an individualized plan of care.

Measurable goals

The list below is a brief description of some of our measurable goals.

- Improve access to essential services including medical, behavioral health, and social services by providing a comprehensive network. Every SNP member will be assigned a case manager with licensed social workers readily available.
- Require SNP members to select a primary care physician (PCP) and assign a THP case manager to the member.
- Streamline the process of transition of care across health care settings, providers, and health services coordinated by the physician/provider and the care manager.
- Improve access to preventive care.
- Improve member health outcomes through participating in annual Healthcare Effectiveness Data and Information Set (HEDIS®) data collection, as well as member surveys.

Provider reimbursement and billing

The provider will bill The Health Plan for medically appropriate covered services provided to the D-SNP member. The Health Plan will reimburse the provider for services rendered, according to the member's benefit plan, less any copays, coinsurance, or deductible amounts. The provider will then be eligible to submit any balance associated with the copays, co-insurance, and deductible directly to the West Virginia or Ohio Medicaid program.

Changes in reimbursement/fee schedules issued by federal and/or state entities will become effective by The Health Plan on the date of notification.



Provider education

THP conducts provider education through several approaches including face-to-face or web-based training, seminars and ProviderFocus newsletter articles.

To access our MOC and the D-SNP MOC Annual Training presentations are on the secure provider portal under "Resource Library," "Training and Education."

To obtain referrals or eligibility information please call our Customer Service Department at 1.877.847.7907.

Federal law prohibits Medicare providers from collecting Medicare Part A and Medicare Part B deductibles, co-insurance, or copayments from those enrolled in the dual-eligible program. This program exempts individuals from Medicare cost-sharing liability. Medicare providers must accept the Medicare payment and Medicaid payment (if any) as payment in full for services rendered to an eligible member. Providers who bill a qualified dual-eligible member for amounts above the Medicare and Medicaid payments (even when Medicaid pays nothing) are subject to sanctions. See Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the Balanced Budget Act of 1997. This section of the act is available [here](#).

Providers may not discriminate by refusing to serve enrollees because they receive assistance with Medicare cost-sharing from a state Medicaid program.

If a provider who is balance billing or refusing to take D-SNP patients is referred to The Health Plan for education, we will send Medicare MLN Matters documents to the provider and document the training. This policy is included in this section of the Provider Procedural Manual and published periodically in our quarterly ProviderFocus newsletter.

Coordination of Benefits Medicare Advantage Secondary Payer

Medicare Advantage is not always the primary payer for health insurance claims. The Health Plan will comply with the Centers for Medicare and Medicaid Services' (CMS) requirement to provide information pertaining to claims in which Medicare Advantage is secondary. Medicare Advantage is the secondary payer when the beneficiary is entitled to:

- Veteran's Benefits
- Workers' Compensation
- Black Lung Benefits
- Employer Group coverage based on the Medicare secondary payer guidelines.

THP Insurance Company Medicare Supplemental Plans

Medicare beneficiaries who have Medicare as their primary insurance pay a monthly premium to The Health Plan to cover their Medicare deductibles and coinsurance. The Plan provides benefit packages that Medicare designed and administers all aspects of the plan in accordance with Medicare guidelines. These plans DO NOT require a member to choose a primary care physician (PCP) or obtain a referral for specialty physician services.



Medicare Non-Covered Service Guidelines

The Health Plan Medicare Advantage plans, SecureCare (HMO), SecureChoice (PPO), or SecureCare SNP (HMO SNP), fall under Medicare Advantage (Part C) rules. These rules require The Health Plan to provide appropriate notice of non-coverage/coverage to the members and educate providers on 1) coverage and exclusions of medical services; 2) limits of plan coverage; and 3) how to correctly advise members prior to providing services of such limitations or service exclusion under Medicare. To ensure that providers understand your role and responsibility regarding covered and non-covered medical services, we are providing this training information as a guide.

Providing Notice of Non-Coverage

The first method The Health Plan utilizes to educate members of non-covered services is provided upon enrollment, through the Evidence of Coverage (EOC) booklet Chapter 4, Section 3: "What services are not covered by the plan?"

The second method is provided through the "Notice of Denial (or partial denial) of Medical Coverage" issued through the pre-service determination (also known as "prior authorization", coverage determination or organization determination) process.

Lastly, for every service billed to The Health Plan for payment, the member receives an Explanation of Benefits (EOB) that provides an explanation of the charges and what, if any, the member is financially responsible for paying to the provider.

Unsure if Covered

For a service or item that is typically not covered, but could be covered under specific conditions (e.g., dental care that is necessary to treat an illness or injury), the EOC, in and of itself, is not adequate notice of non-coverage for purposes of determining member financial liability. In such instances, the appropriate process is for the member, or the provider acting on behalf of the member, to request a pre-service determination.

Never Covered

However, if a service is **never** covered by the plan (statutorily excluded from coverage per Medicare rules) and the plan's Evidence of Coverage (EOC) provided to the member is clear that the service or item is never covered, The Health Plan is not required to hold the member harmless from the full cost of the service or item.

Appeal Rights

For any payment or coverage request for service that The Health Plan receives and denies, a standardized denial notice, as stated above, is provided with appeal rights. The member, or you as their treating provider, has the right to appeal any denial of a service or item. THP will not take punitive action against providers who request an expedited resolution or support a member's appeal.



Member Liability

When the provider, or the plan acting on behalf of the provider, can show that a member was notified (via a clear exclusion in the EOC or the standardized denial notice) prior to receipt of the item or service that:

- a) The item or service is not covered by the plan; or
- b) That coverage is available only if the member is referred for the service by a contracted provider and nonetheless, the member receives that item or service in the absence of a referral, the regulation at §422.105(a) does not require that plans hold the member harmless from the full cost of the service or item charged by the provider.

Medicare Advantage Billing Rules are Different

This section explains how and when to bill a member for non-covered services.

As a contracted provider with The Health Plan, you must always submit a claim for payment of services to The Health Plan prior to billing our members, even if you have received a pre-service determination denial.

Billing for Non-covered Services

GY - No pre-service determination was made

Use this modifier to tell us that you informed/explained to the member that in his/her Health Plan EOC there was a "clear" exclusion and the service was not covered.

GA - Pre-service notice of non-coverage was provided by the plan

Use this modifier to tell us that:

- A pre-service determination was requested and the "Notice of Denial (or partial denial) of Medical Coverage" was issued; or
- The member either refused your offer of obtaining a pre-service determination or wanted to proceed with the service.

Note: When using this modifier please also provide the pre-service determination number in field #23 of the CMS1500 form.

When providers bill with these modifiers, the claims are processed with the appropriate codes for member financial liability, and you may bill the member. If you bill for **non-covered** services **without** using the GA or GY modifier, The Health Plan will deny your claim as provider responsibility. If you bill us for **covered** services **with** the GY or GA modifier, The Health Plan will deny your claim for incorrect use of modifier.

Part of your responsibility as a contracted provider is to inform your patients when a service is not covered (or statutorily excluded) by The Health Plan. In order for The Health Plan Medicare department to know if you have given proper notice of non-coverage to our members, you must follow the billing rules and use the modifiers as stated above.

Following the billing rules and appropriate use of the modifiers ensures that you understand when to provide proper notice of non-coverage of medical services to our Medicare Advantage plan members in advance and limits the confusion of coverage and financial responsibility between the members and The Health Plan.



IMPORTANT REMINDER: Improper Use of Advance Notices of Non-Coverage (ABN)

On May 5, 2014, CMS released a memo titled "Improper Use of Advance Notices of Non-coverage", directing all Medicare Advantage organizations (MAO) and their contracted providers to cease with using ABN notices and ABN-like notices as they are not compliant with the Medicare Advantage organization determination requirements. Per CMS, an ABN does not apply in or under the Medicare Advantage context because a MAO member has the right under these statutes and regulations to a pre-service determination prior to receiving services.

For information on this topic, see the Claims Processing Manual Chapter 1 and MLN Booklet: [Medicare Advance Written Notices of Noncoverage ICN 006266](#)

CMS Quality Measures/Standards

Quality healthcare is a high priority for the President, the Department of Health and Human Services (HHS), and the Centers for Medicare & Medicaid Services (CMS). CMS implements quality initiatives to assure quality health care for Medicare beneficiaries through accountability and public disclosure. CMS uses quality measures in its various quality initiatives that include quality improvement, pay for reporting, and public reporting.

What are Quality Measures?

Quality measures are tools that help us measure or quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care. These goals include effective, safe, efficient, patient-centered, equitable, and timely care.

Download the following Medicare Learning Network Booklets:

- [CMS Initial Preventive Physical Examination](#)
- [CMS Annual Wellness Visit](#)
- [CMS Preventive Services](#)



Appointment of Representative Statement for a Medicare Member

To appoint a representative, a Medicare member or their representative should complete the form entitled: Appointment of Representative -CMS-1696 - PDF.

If you do not use form CMS-1696, your appointment must:

- Be in writing and signed and dated by you and your representative.
- Provide a statement appointing the representative to act on your behalf.
- Authorize the release of your personal health information to your representative.
- Include a written explanation of the purpose and scope of the representation.
- List your name and your representative's names, phone numbers, and addresses.
- Include your Medicare Number (Health Insurance Claim Number or Medicare Beneficiary Identifier) or National Provider Identifier (NPI)
- Indicate your representative's professional status, if any, or relationship to you; and
- Be filed with the entity processing your appeal.

Unless revoked, an appointment is considered valid for one year from the date the form is signed.

Once the form is filed, it is valid for the duration of the appeal. Therefore, a signed form can be used for more than one appeal as long as the appeal is filed within one year of the date on the form.

In addition, there are certain individuals who can bring an appeal on the member's behalf, pursuant to State or other applicable laws. Such an individual, known as an "authorized representative," may be a court-appointed guardian, an individual who has durable power of attorney, a health care proxy, or a person designated under a state's health care consent statute.

Appointment of Representative Forms are available [English](#), [Spanish](#) & [Large Print](#).



Notice of Medicare Non-Coverage (NOMNC)

When to Deliver the NOMNC

A Medicare provider, or The Health Plan, must deliver a completed copy of the Notice of Medicare Non-Coverage (NOMNC) to beneficiaries/enrollees receiving covered skilled nursing, home health (including psychiatric home health), comprehensive outpatient rehabilitation facility, and hospice services.

The NOMNC must be delivered at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily.

Provider Delivery of the NOMNC

Providers must deliver the NOMNC to all beneficiaries eligible for the expedited determination process per section §260 of Chapter 30 of the Medicare Claim Processing Manual or Section 100.2 in the Part C & D Enrollee Grievances, Organization/Coverage Determination, and Appeals Guidance Section of the [Medicare Managed Care Manual](#).

A NOMNC must be delivered even if the beneficiary agrees with the termination of services. Medicare providers are responsible for the delivery of the NOMNC. Providers may formally delegate the delivery of the notices to a designated agent such as a courier service; however, all requirements of valid notice delivery apply to designated agents.

The provider must ensure that the beneficiary or representative signs and dates the NOMNC to demonstrate that the beneficiary or representative received the notice and understands that the termination decision may be disputed. Use of assistive devices may be used to obtain a signature.

Instructions and CMS Form 10055 are available on the [CMS website](#).



Medicare Outpatient Observation Notice (MOON)

On August 6, 2015, Congress passed the Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act, which requires all hospitals and critical access hospitals (CAHs) to provide written and oral notification to all Medicare beneficiaries receiving observation services as outpatients for more than twenty-four (24) hours. The written notice must include the reason the individual is receiving observation services and must explain the implications of receiving outpatient observation services, in particular the implications for cost-sharing requirements and subsequent coverage eligibility for services furnished by a skilled nursing facility.

The **Medicare Outpatient Observation Notice (MOON)** was developed by the Centers for Medicare & Medicaid Services (CMS) to serve as the standardized written notice. Effective March 8, 2017, the MOON must be presented to Medicare beneficiaries, including those with Medicare Advantage plans, to inform them that the observation services they are receiving are outpatient services and that they are not an inpatient of the hospital or CAH. Hospitals and CAHs must deliver the notice **no later than thirty-six (36) hours** after observation services are initiated, or sooner if the individual is transferred, discharged, or admitted.

The hospital or CAH must obtain the signature of the patient or a person acting on behalf of the patient ("representative") to acknowledge receipt of the notification. If the individual or representative refuses to sign it, the written notification is signed by the hospital staff member who presented it.

The CMS approved standardized MOON form (CMS-10611) and accompanying instructions are available on the [CMS website](#).

The Health Plan will monitor hospitals and critical care hospitals annually for compliance to valid delivery of the MOON.



Medicare Appeals Overview

When an enrollee requests coverage for a particular service, the decision on whether to provide such coverage is considered an “Organization Determination.” Enrollees have the right within 60 days of a denial to request either a standard pre-service (30-day), a post service claim (60-day) or an expedited (72 hours) reconsideration whenever a Medicare Advantage organization has denied an enrollee’s request for services, Part B drugs will have a standard turn-around time of 7 days effective January 1, 2020

Where the Medicare Advantage organization affirms its advice “Organization Determination” in whole or in part, the Medicare Advantage organization must automatically forward the case file to CMS’s independent review entity so that it may make a final reconsidered determination. CMS contracts with MAXIMUS Federal Service, Inc.

The parties to an organization determination for purposes of an appeal include:

- The enrollee (including their representative)
- An assignee of the enrollee (i.e., a physician or other provider who has furnished a service to the enrollee and formally agrees to waive any right to payment from the enrollee for that service)
- The legal representative of a deceased enrollee’s estate; or
- Any other provider or entity (other than the Medicare health plan) determined to have an appealable interest in the proceeding.

Who may request reconsideration (Chapter 13 Medicare Managed Care Manual – 70.1)

An enrollee, an enrollee’s representative or a non-contract physician or provider to the Medicare health plan may request that the determination be reconsidered; however, contract providers do not have appeal rights. An enrollee, an enrollee’s representative, or physician (regardless of whether the physician is affiliated with the Medicare health plan) are the only parties who may request that a Medicare health plan expedite a reconsideration.

For standard pre-service reconsiderations, a physician who is providing treatment to an enrollee may, upon providing notice to the enrollee, request a standard reconsideration on the enrollee’s behalf without submitting a representative form.

If the reconsideration request comes from the enrollee’s primary care physician in The Health Plan’s contract network, no enrollee notice verification is required.

If the request comes from either an in-network (contract) physician or a non-contract physician, and the patient’s record indicates he or she visited this physician at least once before, a Medicare health plan may assume the physician has informed the enrollee about the request and no further verification is needed.

If this appears to be the first contact between the physician requesting the reconsideration and the enrollee, a Medicare health plan is to undertake reasonable efforts to confirm the physician has given the enrollee appropriate notice. For example:

- If the physician makes the request by phone, during the call a health plan may confirm the physician gave the enrollee notice that he or she is acting on the enrollee’s behalf.
- The physician makes the request by a fax, letter, or email, and copies the enrollee on the correspondence, and/or the writing includes a statement affirming that the enrollee knows that the physician is acting on the enrollee’s behalf with the enrollee’s knowledge and approval.



- The Medicare health plan may call the enrollee and ask if he or she knows that this physician making the request is acting on his or her behalf with his or her knowledge and approval. Notice of Medicare Hospital Discharge Appeals Notices

Notice of Medicare Hospital Discharge Appeals Notices

An Important Message from Medicare about Your Rights (Form CMS-R-193)

Hospitals are required to deliver the Important Message from Medicare (IM), CMS-R-193, to all Medicare beneficiaries (Original Medicare beneficiaries and Medicare Advantage plan enrollees) who are hospital inpatients. The IM informs hospitalized inpatient beneficiaries of their hospital discharge appeal rights. A detailed notice of discharge (DND) is given only if a beneficiary requests an appeal. The DND explains the specific reasons for the discharge.

Forms and instructions can be found on the [CMS website](#).

Detailed Notice of Discharge (Form CMS 10066)

A member who wishes to appeal the determination made by the facility or The Health Plan that inpatient care is no longer medically necessary must request an immediate review by the peer review organization (PRO) of the determination. The member must request the immediate PRO review by noon of the first working day after receipt of the notice. The member will not be financially responsible for the hospital care until the PRO makes its decision. If the admission was not authorized by The Health Plan or the admission did not constitute emergency or urgently needed care and the PRO upholds The Health Plan's determination, the member is financially responsible for the hospital costs.

A member who fails to request an immediate PRO review may request expedited reconsideration by The Health Plan through the appeal process.

Forms and instructions can be found on the [CMS website](#).

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 coinsurance, copayments and deductibles from those enrolled in the QMB program, including those enrolled in Medicare Advantage and other Part C Plans.

For changes from July 1, 2018, refer to the [CMS MedLearn Matters article](#) for further guidance:

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. A patient should not get 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)



Medicare Provider Rights and Responsibilities

It is imperative that you be aware of these rights and responsibilities as a participating provider with The Health Plan so that you may assist our members by making them aware of their rights and by supporting these within your practice. Please refer to this section of the manual for important information regarding CMS quality standards that you are required to meet when caring for Medicare Advantage enrollees. Customer Service is available to assist with any member issues that may arise by calling 1.877.847.7907 or visiting medicare2021.healthplan.org.

Overview of Physician Responsibilities

Primary Care Physicians (PCPs):

- Act as a health care manager for members to arrange and coordinate their medical care, including but not limited to, routine care, and follow-up care after the receipt of emergency services.

Specialists:

- Provide continuity and coordination of care by sending a written report to PCPs regarding any treatment or consultation provided to members, regardless of whether the service was a result of a PCP referral or the member making his/her own arrangements.

All Contracted Physician Must

- Arrange for the provision of medical services to The Health Plan's members by a participating practitioner after hours, on weekends, vacations, and holidays. Services from non-participating covering practitioners may not be covered, unless otherwise approved by The Health Plan.
- Have 24-hour on-call capability, either directly or through an answering service, not an answering machine.
- Help members obtain their benefit coverage by getting written prior authorization for services that require it and prior to referring for out-of-plan services, as appropriate.
- Facilitate candid discussion with members regarding appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage. Such discussion should include complete and current information concerning a diagnosis, treatment, and prognosis, in terms that the member (or designee) can be expected to understand.
- Provide to members the information necessary to give informed consent prior to the start of any procedure or treatment.
- Maintain appropriate medical records regarding members and their treatment, recognizing that said records are confidential and ensuring that they are maintained in accordance with legal and ethical requirements concerning confidentiality and security.
- Cooperate with The Health Plan, or its designee, in the resolution of members' complaints, expedited appeals, appeals and/or grievances.
- Comply with other administrative requirements as specified in the applicable contract or stipulated in this Provider Manual or its updates.
- Promote the efficient delivery of medical services to maximize health care resources and the member's premium dollar and improve quality of care provided.
- Refrain from providing treatment to the physician's own family members.
- Provide medical information in a culturally competent manner to all members, including those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities.



NCQA Requirements:

- Comply with The Health Plan medical records policy, quality assurance programs, medical management programs, and HEDIS® data collection.

CMS Marketing Guidelines:

- Comply with [CMS Marketing Guidelines](#) for provider-based activities. The guidelines, available below, govern how providers can and cannot inform or educate patients about enrollment and plan information.



SecureCare/SecureChoice Rights and Responsibilities

An excerpt from THP's Medicare Member Handbook

Our plan must honor your rights as a member of the plan.

We must provide information in a way that works for you (in languages other than English, in Braille, in large print, or other alternate formats, etc.)

To receive information from us in a way that works for you, please call Member Services at 1.877.847.7907.

Our plan has people and free interpreter services available to answer questions from disabled and non-English speaking members. We can also give you information in Braille, large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Member Services at 1.877.847.7907 or contact our Director of Medicare.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with The Health Plan Appeals Coordinator at 1.877.847.7907 (TTY: 711). You may also file a complaint with Medicare by calling 1.800.MEDICARE (1.800.633.4227) or directly with the Office for Civil rights. Contact information is included in the Evidence of Coverage or you may contact Member Services for additional information.

We must treat you with fairness and respect at all times

Our plan must obey laws that protect you from discrimination or unfair treatment. We do not discriminate based on a person's race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' Office for Civil Rights at 1.800.368.1019 (TTY: 1.800.537.7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call us at Member Services at 1.877.847.7907. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

We must ensure that you get timely access to your covered services and drugs

As a member of our plan, you have the right to choose a primary care provider (PCP) in the plan's network to provide and arrange for your covered services (Chapter 3 explains more about this). Call Member Services to learn which doctors are accepting new patients at 1.877.847.7907. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

As a plan member, you have the right to get appointments and covered services from the plan's network of providers within a reasonable amount of time. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.



If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9, Section 10 of this booklet tells what you can do. (If we have denied coverage for your medical care or drugs and you do not agree with our decision, Chapter 9, Section 4 tells what you can do.)

We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your “personal health information” includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a “Notice of Privacy Practice,” that tells you about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people do not see or change your records.
- In most situations, if we give your health information to anyone who is not providing your care or paying for your care, we are required to obtain written permission from you first. Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
 - For example, we are required to release health information to government agencies that are checking on quality of care.
 - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your healthcare provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Member Services at 1.877.847.7907.



We must give you information about the plan, its network of providers, and your covered services

As a member of SecureCare (HMO) or SecureChoice (PPO), you have the right to get several kinds of information from us. (As explained above, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.)

If you want any of the following kinds of information, please call Member Services at 1.877.847.7907:

- Information about our plan. This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- Information about our network providers including our network pharmacies.
 - For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
 - For a list of the providers in the plan's network, see the Plan Provider Directory.
 - For a list of the pharmacies in the plan's network, see the Plan Pharmacy Directory.
 - For more detailed information about our providers or pharmacies, you can call Member Services at 1.877.847.7907 or visit our website at medicare2022.healthplan.org.
- Information about your coverage and the rules you must follow when using your coverage.
 - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
 - To get the details on your Part D prescription drug coverage, see Chapters 5 and 6 of this booklet plus the plan's List of Covered Drugs (Formulary). These chapters, together with the List of Covered Drugs (Formulary), tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
 - If you have questions about the rules or restrictions, please call Member Services at 1.877.847.7907.
- Information about why something is not covered and what you can do about it.
 - If a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network provider or pharmacy.
 - If you are not happy or if you disagree with a decision, we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 9 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 9 also tells you about how to make a complaint about quality of care, waiting times, and other concerns.)
 - If you want to ask our plan to pay our share of a bill you have received for medical care or a Part D prescription drug, see Chapter 7 of this booklet.



- Utilization Review. The Health Plan has a Utilization Management Program in place that monitors the use of, or evaluates the clinical necessity, appropriateness, efficacy or efficiency of, health care services, procedures or care settings. Areas of utilization management include:
 - Prior authorization of health care services, for example elective admissions, home health services, durable medical equipment or imaging studies. Prior authorizations may be for non-urgent services, urgent services or post services. The decisions for prior authorizations are made within strict time frames to minimize any disruption in the provision of health care. Non-authorization decisions are communicated to members and providers within strict time frames with sufficient information to understand the reason for the non-authorization and to decide whether to appeal the non-authorization. Only medical directors who are physicians may not authorize services for medical necessity.
 - Hospital inpatient review– Clinical information is received from hospitals that enable registered nurses at The Health Plan to assist with post-hospital care needs and arranging services to ensure care across the continuum.
 - Care/case management is a personalized process to assess treatment options and opportunities to coordinate care, design care plans to improve quality and efficacy of care, manage cost and benefits patient care to ensure optimal outcomes for members with catastrophic illness or those needing episodic management of health care needs. Registered nurses perform the functions of utilization management.
- New Technology
 - The Health Plan tries to keep pace with change and ensure members have access to safe and effective care. The Health Plan continually reviews new trends in medical technology, procedures, pharmacological treatments and drugs. Scientific evidence, medical effectiveness and determinations from regulatory bodies are all components of the review of new technology. The Health Plan reviews this information to form the basis for coverage decisions in the future.

We must support your right to make decisions about your care.

You have the right to know your treatment options and participate in decisions about your health care.

You have the right to get full information from your doctors and other health care providers when you go for medical care. Your providers must explain your medical condition and your treatment choices in a way that you can understand.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- To know about all of your choices. This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- To know about the risks. You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.



- The right to say “no.” You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.
- To receive an explanation if you are denied coverage for care. You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 9 of this booklet tells how to ask the plan for a coverage decision.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself.

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, if you want to, you can:

- Fill out a written form to give someone the legal authority to make medical decisions for you if you ever become unable to make decisions for yourself.
- Give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called “advance directives.” There are different types of advance directives and different names for them. Documents called “living will” and “power of attorney for health care” are examples of advance directives.

If you want to use an “advance directive” to give your instructions, here is what to do:

- Get the form. If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Member Services to ask for the forms at 1.877.847.7907.
- Fill it out and sign it. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- Give copies to appropriate people. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital.

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.



Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with Probate Court in the county in which you reside.

You have the right to make complaints and to ask us to reconsider decisions we have made.

If you have any problems or concerns about your covered services or care, Chapter 9 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints. What you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – we are required to treat you fairly.

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Member Services at 1.877.847.7907.

What can you do if you believe you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights.

If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' Office for Civil Rights at 1.800.368.1019 or TTY 1.800.537.7697 or call your local Office for Civil Rights.

Is it about something else?

If you believe you have been treated unfairly or your rights have not been respected, and it's not about discrimination, you can get help dealing with the problem you are having:

- You can call Member Services at 1.877.847.7907.
- You can call the State Health Insurance Assistance Program. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- Or, you can call Medicare at 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.

How to get more information about your rights

There are several places where you can get more information about your rights:

- You can call Member Services (phone numbers are printed on the back cover of this booklet).
- You can call the SHIP. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact Medicare.
 - Visit the Medicare website to read or download "[Your Medicare Rights & Protections](#)"
 - Call 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week (TTY:1.877.486.2048)



You have some responsibilities as a member of the plan.

What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call Member Services at 1.877.847.7907. We're here to help.

- Get familiar with your covered services and the rules you must follow to get these covered services. Use this Evidence of Coverage booklet to learn what is covered for you and the rules you need to follow to get your covered services.
 - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
 - Chapters 5 and 6 give the details about your coverage for Part D prescription drugs.
- If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us. Please call Member Services to let us know at 1.877.847.7907.
 - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called "coordination of benefits" because it involves coordinating the health and drug benefits you get from our plan with any other health and drug benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 10.)
- Tell your doctor and other health care providers that you are enrolled in our plan. Show your plan membership card whenever you get your medical care or Part D prescription drugs.
- Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.
 - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
 - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
 - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
- Be considerate. We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- Pay what you owe. As a plan member, you are responsible for these payments:
 - You must pay your plan premiums to continue being a member of our plan.
 - In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B. For that reason, some plan members must pay a premium for Medicare Part A and most plan members must pay a premium for Medicare Part B to remain a member of the plan.



- For most of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). Chapter 4 tells what you must pay for your medical services. Chapter 6 tells what you must pay for your Part D prescription drugs.
- If you get any medical services or drugs that are not covered by our plan or by other insurance, you may have, you must pay the full cost.
 - If you disagree with our decision to deny coverage for a service or drug, you can make an appeal. Please see Chapter 9 of this booklet for information about how to make an appeal.
- If you are required to pay a late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.
- If you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount directly to the government to remain a member of the plan.
- Tell us if you move. If you are going to move, it's important to tell us right away. Call Member Services at 1.877.847.7907.
 - If you move outside of our plan service area, you cannot remain a member of our plan. (Chapter 1 tells you about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a Special Enrollment Period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.
 - If you move within our service area, we still need to know so we can keep your membership record up to date and know how to contact you.
 - If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.
- Call Member Services for help if you have questions or concerns. We also welcome any suggestions you may have for improving our plan.
 - Call Member Services at 1.877.847.7907.
 - For more information on how to reach us, including our mailing address, please see Chapter 2.
- Contacting Utilization Review Staff
 - During business hours 8:00 AM – 5:00 PM Monday through Friday, you may call us toll free at 1.800.624.6961, ext. 7644.
 - After 5:00 PM Monday through Friday, you may call us toll free at 1.800.624.6961.

Section 5

Medicaid





Mountain Health Trust (MHT) Program

Program includes WV Medicaid, Temporary Assistance for Needy Families (TANF), WV Health Bridge (Expansion), Supplemental Security Insurance (SSI) and West Virginia Children's Health Insurance Program (WVCHIP) membership.

The Health Plan (THP) began administering health care benefits to WV Medicaid Members on September 1, 1996 and WVCHIP members on January 1, 2021. THP currently serves all 55 counties in West Virginia.

Mountain Health Trust ID Cards and Eligibility

Mountain Health Trust members will have one ID card issued by The Health Plan.

The member should always present their ID card when receiving services. Each eligible individual family member will have a separate ID card with their own plan ID number. The Health Plan ID card has the applicable program logo and important lines of information:

- Member's plan ID # including – 01 suffix (important for billing correctly)
- DHHR assigned member ID number
- Member's name
- Member's PCP name
- PCP phone number

The Health Plan sends an ID card to the member once, unless the member changes PCPs or loses the card and requests another one.

All members, except newborns, become effective on the first of each month and could term on the last day of the month. If you have any eligibility questions, please call the Customer Service Department at 1.888.613.8385 to verify coverage or visit THP's secure [provider portal](#). If you do not have access to this site, please contact:

Provider Relations – EDI Support
Phone: 1.800.624.6961, ext. 6248
Email: hpecs@healthplan.org
Fax: 740.695.7883

When medically necessary, The Health Plan makes services available 24 hours a day, seven days a week. Physicians must comply with the access standards set forth in **Section 2** of the provider manual.

THP must cover out-of-network services that are otherwise covered under the Mountain Health Trust Contract for the member if THP's network is unable to provide such services. THP must ensure that the cost to the member is no greater than it would be if the services were furnished within the network. Services must be covered as adequately and timely as if such services were provided within the network, and for as long as THP is unable to provide them. To the extent possible, THP must encourage out-of-network providers to coordinate with THP with respect to payment.

THP regularly measures the extent to which providers in the network comply with these requirements and take remedial action if necessary. THP must ensure that services are provided in a culturally competent manner to all members, including those with limited English proficiency or reading skills, those with diverse cultural and ethnic backgrounds, the homeless, and individuals with physical and mental disabilities, regardless of gender, sexual orientation, or gender identity. THP also ensures that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities.



Mountain Health Trust ID Cards

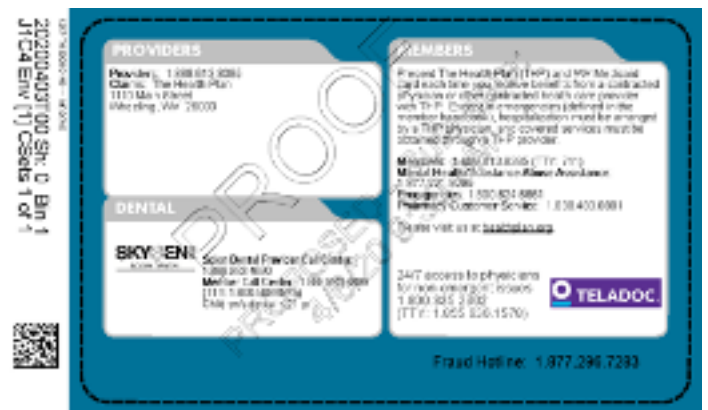
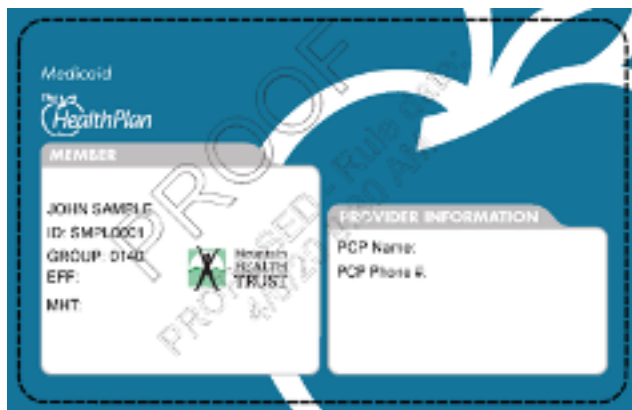
TANF and SSI ID Cards

Group number: 0140 and 0142

The THP Medicaid ID cards are color-coded blue for ease in identifying the Medicaid population. If you have any questions, please contact our Customer Service Department at 1.888.613.8385.

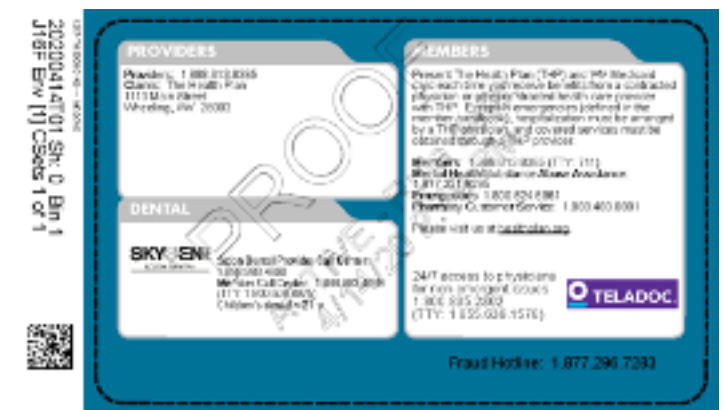
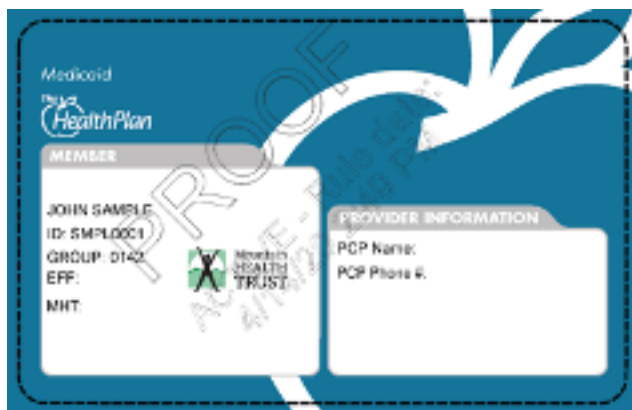
TANF ID Card

Group number: 0140



SSI ID Card

Group number: 0142

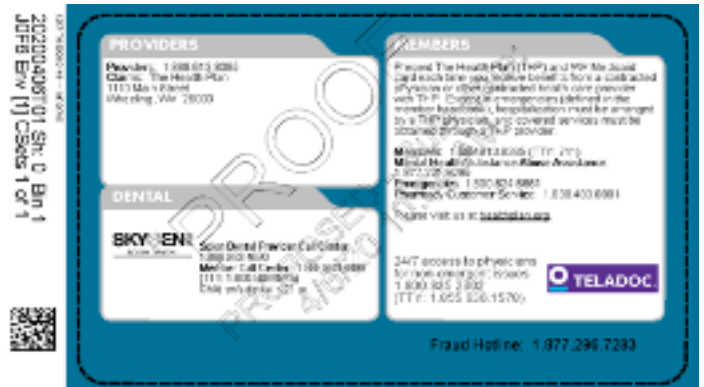
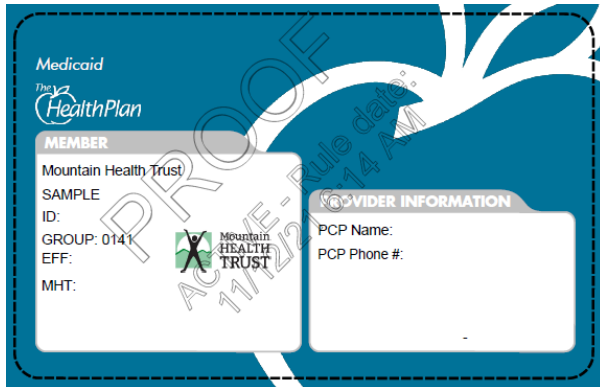




WV Health Bridge ID Cards

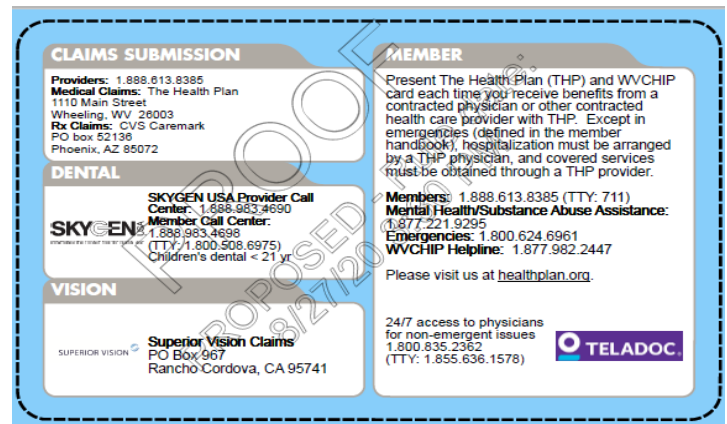
The THP Medicaid ID cards are color-coded blue for ease in identifying the Medicaid population. If you have any questions, please contact our Customer Service Department at 1.888.613.8385.

Group number: 0141



WVCHIP ID Card

The THP WVCHIP cards are color-coded light blue for ease in identifying the WVCHIP population. If you have any questions, please contact our Customer Service Department at 1.888.613.8385.





Medicaid Benefits and Exclusions at a Glance

Mountain Health Trust & West Virginia Health Bridge Covered Benefits

Medical

- **Primary Care/Specialist Office Visits/FQHC/RHC**– Includes physician, physician assistant, nurse practitioner and nurse midwife services.
- **Physician Services**– Certain services may require prior authorization or have service limits. May be delivered through telehealth.
- **Laboratory and X-ray Services**– Includes lab services related to substance abuse treatment. Services must be ordered by a physician and certain procedures have service limits. Genetic testing requires prior authorization.
- **Clinics**– Includes general clinics, birthing centers, and health department clinics. Vaccinations are included for children.
- **Private Duty Nursing**– For children ages 0-21. Requires prior authorization. Limits apply.

Hospital

- **Inpatient**– Includes all inpatient services (including bariatric and corneal transplants). Transplant services must be in a center approved by Medicare and Medicaid and covered under fee-for-service. Some behavioral health inpatient stays are not included. Requires prior authorization.
- **Organ and Tissue Transplants**– Corneal transplants only.
- **Outpatient**– Includes preventative, diagnostic, therapeutic, all emergency services, and rehabilitative medical services.

Ambulatory Surgical Care

- Includes services and equipment for surgical procedures.

Emergency

- **Post-stabilization**– Includes care after an emergency health condition is under control. Care provided in a hospital or other setting.
- **Emergency Transportation**– Includes ambulance and air ambulance. Out-of-state requires prior authorization.

Rehabilitation

- **Pulmonary Rehabilitation**– Includes procedures to increase strength of respiratory muscle and functions. Must meet plan guidelines. Maximum of 12 weeks or 36 visits per calendar year.
- **Cardiac Rehabilitation**– Includes supervised exercise sessions with EKG monitoring. Limited to a maximum of 12 weeks or 36 visits per heart attack or heart surgery.
- **Inpatient Rehabilitation**– Services related to inpatient facilities that provide rehabilitation services for Medicaid eligible individuals (in a rehabilitation facility; limited to 60 days per calendar year). Requires prior authorization.



Mountain Health Trust & West Virginia Health Bridge Covered Benefits

Specialty

- **Podiatry**— Includes treatment of acute conditions for children and adults. Includes some surgeries, reduction of fractures and other injuries, and orthotics. Routine foot care is not covered. Surgical procedures other than in-office require prior authorization.
- **Physical and Occupational Therapy**—Combined 20 visits per year for habilitative and rehabilitative services. Prior authorization required on the 21st visit.
- **Speech Therapy—For children (ages 0-21):** Prior authorization required. The benefit limit is 20 visits per calendar year. For adults (21 and older): Limited to specific medical/surgical conditions and prior authorization is required.
- **Chiropractor**— Limited to manual manipulation of the spine and X-ray exam related to service. Any chiropractor properly qualified may engage in the use of physiotherapeutic devices, physiotherapeutic modalities, physical therapy and physical therapy techniques. Chiropractic, physical therapy (PT), occupational therapy (OT), and osteopathic manipulation are permitted when performed by a chiropractor for chronic pain management. Coverage is limited to (20) chiro/PT/OT/osteopathic manipulation combined visits per qualifying event (e.g., broken arm).
- **Handicapped Children's Services/Children with Special Health Care Needs Services**— Includes coordinated services and limited medical services, equipment and suppliers (for children only).
- **Nutritionist**—Medical nutritionist visits are limited to six visits per calendar year. Medical nutritionist visits for weight loss only if part of evaluation for bariatric surgery requires prior authorization.

Preventive Care and Disease Management

- **EPSDT**— (ages 0-21) Includes health care services for any medical or psychological condition discovered during screening (for children only). Needs that are identified that are over the allowable or not included in the covered services require prior authorization.
- **Tobacco Cessation**—Includes therapy, counseling, and services. Guidance and risk-reduction counseling covered for children.
- **Sexually Transmitted Disease Services**—Includes screening for a sexually transmitted disease from a PCP or a specialist in our network.
- **Preventive Screenings**
 - Annual pap smear for cervical cancer screening beginning at age 18, earlier if medically necessary.
 - Mammography screening: Ages 35-39 at least once, 40-49 every two years unless medically determined that member is at risk, one every year and 50+ one every year.
 - Prostate cancer screening: Beginning at age 50.
 - Colorectal screening: Age 50 and older without symptoms or under age 50 with symptoms.

Maternity

- **Right From The Start**—Includes prenatal care and care coordination. Services covered through 60-day post-partum and infants less than one year old.
- **Family Planning**—Services to aid recipients of childbearing age to voluntarily control family size or to avoid or delay an initial pregnancy. Pregnancy terminations and infertility treatments are not covered.
- **Maternity Care**—Includes prenatal, inpatient hospital stays during delivery, and post-partum care. Home birth is not covered.



Mountain Health Trust & West Virginia Health Bridge Covered Benefits

Durable Medical Equipment, Orthotics and Prosthetics

- Requires prior authorization and must meet The Health Plan guidelines.
- Limited replacements.
- Other limitations may apply.

Hospice

Requires prior authorization for all visits. If the member revokes three times, the member is no longer eligible for hospice. For adults, rights are waived to other Medicaid services related to the terminal illness.

Home Health Care

Covered for nursing, physical therapy, occupational therapy, and speech therapy. Includes services given at member's residence. This does not include a hospital nursing facility, ICF/MR, or state institutions. Prior authorization required prior to second certification period.

Dental

- **For children (ages 0-21)**
 - Must use participating practitioners (see provider directory or call Skygen Dental).
 - Orthodontics covered for the entire duration of treatment regardless of loss of eligibility. Requires prior authorization.
- **For adults (21 and older)**
 - Must use participating practitioners (see provider directory or call Skygen Dental).
 - \$1,000 benefit for preventive and restorative dental care
 - Emergency dental procedures
 - TMJ is not covered for adults.

Vision

- **For children (ages 0-21)**
 - Must use participating vision services practitioners. See provider directory or call Superior Vision.
 - Vision screening and therapy.
 - One eye exam covered once every 12 months.
 - Limited one frame per year.
 - Contact lenses covered for certain diagnoses.
 - Repairs.
- **For adults (21 and older)**
 - Adults limited to medical treatment only.
 - Medical contact lenses for adults and children covered for certain diagnoses.
 - One pair of glasses up to 60 days after cataract surgery.

Diabetes Management

Members diagnosed with diabetes have the right to access vision services without a PCP referral for an annual examination. If annual exam reveals abnormal conditions, any follow-up appointment with a specialist will require prior authorization from the member's PCP.



Mountain Health Trust & West Virginia Health Bridge Covered Benefits

Hearing

- **For children (ages 0–21)**
 - Requires prior authorization.
 - Audiology screening (only if referred by a PCP or ENT practitioner).
 - One hearing aid every five years.
 - Hearing aid evaluations, hearing aid supplies, batteries, and repairs. Certain procedures may have service limits or require prior authorization. Augmentation communication devices limited to children under 21 years of age and require prior approval.
- **For adults (21 and older)**
 - Requires prior authorization.
- Covered for specific medical conditions.

Behavioral Health

- **Behavioral Health Rehabilitation/Psychiatric Residential Treatment Facility** – Includes services for children (up to age 21) with mental illness and substance use disorder. Limited frequency and amount of services. Certain services require prior authorization. Children's residential treatment is not covered.
- **Inpatient Psychiatric Services under age 21** – Includes behavioral health and substance use disorder hospital stays at a psychiatric hospital or a distinct part psychiatric unit of an acute care hospital. Requires prior authorization. Children's residential treatment is not covered
- **Inpatient Psychiatric Services for ages 21-64** – Includes behavioral health and substance use disorder hospital stays at a psychiatric hospital or a distinct part psychiatric unit of an acute care hospital. Requires prior authorization.
- **Outpatient** – Includes services for individuals with mental illness and substance use disorder. Providers of ACT and IOP must be certified by the BMS. Certain services require prior authorization. Most services may be provided by telehealth.
- **Psychological Testing**– Some evaluation and testing procedures have frequency restrictions.
- **Drug Screening** – Laboratory services to screen for presence of one or more drugs of use. Limits apply and prior authorization is required for some testing.
- **Substance Use Disorder (SUD) Services** – Targeted case management, residential services, peer recovery support services and counseling services to treat those with substance use disorder. Prior authorization is required for some services.

Applied Behavior Analysis (ABA)

- For members with a primary diagnosis of Autism Spectrum Disorder
- ABA benefits can continue as long as treatment is determined medically necessary, continues to exhibit consistent progress at three-month intervals, and is in accordance with treatment plan requirements described in this policy guideline

*There are additional services to those included on this list. If you have questions on whether a service is covered, give us a call.



| Benefits Under Fee-for-Service Medicaid | |
|---|--|
| Abortion | Includes drugs, devices, and procedures for termination of ectopic pregnancy. Physician certification required. |
| Early Intervention Services for Children Three and Under | |
| Nursing Facility Services | Includes nursing, social services, and therapy. |
| Personal Care Services | Includes personal hygiene, dressing, feeding, nutrition, environmental support, and health-related functions. Room and board services require physician certification. May not exceed 60 hours per month without prior authorization. |
| Personal Care for Aged/Disabled | Includes assistance with daily living in a community living arrangement, grooming, hygiene, nutrition, physical assistance, and environmental for individuals in the Age/ Disabled Waiver. Limited on per unit per month basis. Requires physician order and nursing plan of care. |
| ICF/MR Intermediate Care Facility | Includes physician and nursing services, dental, vision, hearing, lab, dietary, recreational, social services, psychological, habilitation, and active treatment for the mentally retarded. Requires physician or psychiatrist certification. |
| Prescription Drugs | Includes dispensed on an ambulatory basis by a pharmacy, family planning supplies, diabetic supplies, vitamins for children, and prenatal vitamins. Hemophilia blood factor, Hepatitis-C, weight gain, cosmetic, hair growth, fertility, less than effective, and experimental drugs are not covered. Drugs dispensed by a physician at no cost are not covered. |
| Organ Transplant Services | Generally safe, effective, medically necessary transplants covered when no alternative is available. Cannot be used for investigational/ research nature or for end-stage diseases. Must be used to manage disease. |
| School-based Services | Service limitations are listed in the fee for service Medicaid provider manual. |
| Transportation | Includes multi-passenger van services and common carriers (public railways, buses, cabs, airlines, ambulance as appropriate, and private vehicle transportation). Prior authorization is required by county DHHR staff. To get transportation, call: 1.844.549.8353. |

Exclusions

Some services are not available through The Health Plan or Medicaid. If a member chooses to get these services, the member may have to pay the entire cost of the service. The Health Plan is not responsible for paying for these services and others:

- All non-medically necessary services.
- Except in an emergency, inpatient hospital tests that are not ordered by the attending physician or other licensed practitioner, acting within the scope of practices, who is responsible for the diagnosis or treatment of a particular patient's condition.
- Organ transplants, except in some instances.
- Cosmetic/plastic surgery will be covered only to correct conditions from accidents/injuries like a car accident and birth defects like a cleft lip. Breast implants are covered only for mastectomy due to breast cancer or fibrocystic breast disease.



Exclusions, continued

- Removal/replacement of breast implants must be proven medically necessary. Implants must have been inserted for reconstructive purposes due to mastectomy for breast cancer or fibrocystic breast disease.
- These conditions must have happened while a member of The Health Plan. If not, The Health Plan must determine an ongoing history of medically necessary cosmetic/plastic surgery to correct these conditions. The Health Plan may do so by looking at past medical records.
- Removal of breast implants that were inserted for cosmetic reasons only will not be covered.
- Oral surgery for adults will be covered to correct conditions from accidents/injuries, like a car accident. The accident/injury must have happened while a member of The Health Plan. An oral surgeon *must* be needed to correct these conditions. These services must start within six months of the accident/injury.
- Custodial or home care, rest and respite care, or other services primarily to assist in the activities of daily living and personal comfort items (to include cleansing and luxury items). This includes personal services and residential services.
- Health care that is for research, investigation, or experimental as determined by The Health Plan. The Health Plan will look at standards of the AMA, FDA, NIH, Medicare, or reports of consultants to decide if a health care treatment is experimental or investigational.
- Services based on religious beliefs
- Private rooms are not paid for, except when medically needed and approved by The Health Plan. Personal or comfort items and services like guest meals, lodging, radio, television, and telephone.
- Hospital or medical care for problems that state or local law requires treatment of in a public facility.
- Any injury or sickness when any benefits, settlements, awards, or damages will be received or paid. This includes workers' comp, employer's liability or similar law or act.
- Reversal of voluntary sterilization and associated services and/or expenses
- Sterilization for members under age 21.
- Sex transformation procedures and hormone therapy associated with sex transformation procedures
- Special services not approved by The Health Plan
- Provider and medical services outside the service area unless emergent or prior authorized.
- Hearing aid evaluations, bone-anchored hearing aids, cochlear implants, hearing aids, hearing aid supplies, batteries and repairs will only be covered for members under the age of 21. Coverage depends on hearing loss and The Health Plan guidelines.
- Exams or insurance, sports physicals, camp physicals, or daycare physicals will not be paid for unless it is part of a yearly physical exam given by a PCP.
- Medical and surgical treatment for *all* infertility services
- Abortions are covered by FFS Medicaid.
- Long-term cardiac and pulmonary, physical, respiratory, occupational or speech therapy will only be paid for in certain situations, such as for children.



Exclusions, continued

- Services for acupressure, hypnosis, electrolysis, Christian Science treatment and autopsy. Any education or training classes including Lamaze and to quit tobacco use (unless under RFTS). Estrogen and androgen pellet implants, arch supports, massage, and paternity testing are not covered.
- Liposuction, panniculectomies or abdominoplasty, such as surgery to remove fatty tissue ("tummy tucks").
- Work hardening programs, including functional capacity evaluations
- Services at non-medical weight loss clinics and diet centers, mini-gastric bypass surgery, and gastric balloon for treatment of obesity. Consideration for bariatric surgery and related services require prior authorization. Also included are wiring of the jaw, weight control programs, screening for weight control programs, and similar services.
- Organ transplants and related expenses are covered under fee-for-service
- Vision services for members over age 21 are limited to medical treatment only and require an approved referral to a participating ophthalmologist.
- Practitioner and medical services that are not medically necessary or appropriate as determined by The Health Plan.
- Other limitations specifically stated in the provider and medical benefits list in this handbook.
- Services not provided, arranged, or authorized by the member's practitioner, except in an emergency or when allowed in this policy. Elective pre-surgery testing on an inpatient basis without the authorization of The Health Plan's medical director.
- Sports-related devices.
- Acupuncture, unless it is for anesthesia used with a covered procedure.
- Services by a practitioner with the same legal address or who is a member of the covered person's family. This includes spouse, brothers, sisters, parents, or children.
- Unlicensed services by a practitioner.
- War-related injuries or treatment in a state or federal provider for military or service-related injuries or disabilities.
- Non-medical services related to the treatment of temporomandibular joint dysfunction (TMJ) or craniomandibular joint dysfunction (CMD). WV Medicaid covers TMJ for children up to age 21.
- If a member decides to get hospice services instead of medical treatment, he/she gives up the right to other Mountain Health Trust or West Virginia Health Bridge services for the terminal illness. Coverage continues for other medical conditions not related to the terminal illness.
- Sterilization of a mentally incompetent or institutionalized person.
- Inpatient tests not ordered by the attending practitioner or other licensed practitioner, except in cases of emergency.
- Therapy and related services for a patient showing no progress. Speech therapy for members ages 0-21 must meet criteria and be pre-authorized. Speech therapy for adults is not a covered benefit except when medically needed as a result of specific medical/surgical conditions such as ALS, cerebral palsy, stroke, or physical trauma.
- Non-emergency transportation is covered by FFS Medicaid.



Exclusions, continued

- Services that, in the judgment of the member's practitioner, are not medically appropriate or not required by accepted standards of medical practice or the plan rules governing services.
- Megavitamin therapy and nutrition-based therapy.
- Services performed after the member's physician has advised the member that further services are not medically appropriate or not covered services.
- Homeopathic treatments.
- Treatment for flat foot and subluxation of the foot are not covered.
- Services related to moral or religious objections are not covered.

This is not a complete list of the services that are not covered by The Health Plan. If a service is not covered, not authorized, or is provided by an out-of-network provider, the member may have to pay.



WVCHIP Benefits at a Glance

| WVCHIP | Scope of Benefit |
|-------------------------------------|--|
| Abortion Services | <ul style="list-style-type: none"> Termination of unwanted or endangered pregnancy Covered only in cases of rape, incest, or endangerment to a mother's life |
| Allergy Services | <ul style="list-style-type: none"> Testing and treatment for allergies Includes all testing and related treatment services |
| Applied Behavior Analysis (ABA) | <ul style="list-style-type: none"> For members with a primary diagnosis of Autism Spectrum Disorder Medically necessary ABA treatment is limited to \$30,000 per member per year for three consecutive years from the date treatment starts for a member with a qualifying diagnosis of ASD prior to the member's eighth birthday. After the third consecutive year of treatment, medically necessary ABA treatment coverage is limited to \$2,000 per month until the child attains the highest level of functioning given the diagnosis, his/her 19th birthday or is no longer eligible for WVCHIP ABA benefits can continue as long as treatment is determined medically necessary, continues to exhibit consistent progress at three-month intervals, and is in accordance with treatment plan requirements described in this policy guideline |
| Ambulance Services | <ul style="list-style-type: none"> Emergency ground or air ambulance transport to the nearest facility able to provide needed treatment when medically necessary Facility to facility ground ambulance transportation service that are medically necessary are covered |
| Cardiac or Pulmonary Rehabilitation | <ul style="list-style-type: none"> A comprehensive outpatient program of medical evaluation, prescribed exercise, cardiac risk factor modification, and education and counseling that is designed to restore members with heart disease to active, productive lives. Cardiac rehabilitation can be performed in a specialized, freestanding physician directed clinic or in an outpatient hospital department Limited to 3 sessions per week for 12 weeks or 36 sessions per year for the following conditions: heart attack occurring in the 12 months preceding treatment, heart failure, coronary bypass surgery, or stabilized angina pectoris |
| Chelation Therapy | <ul style="list-style-type: none"> For reduction of lead and other metals |
| Chiropractic Services | <ul style="list-style-type: none"> Services provided by a chiropractor consisting of manual manipulation of the spine Evaluation and management and diagnostic imaging For acute treatment of a neuromuscular-skeletal condition, including office visits and x-rays Prior authorization is required Limited to 20 visits per calendar year |



| WVCHIP | Scope of Benefit |
|--|---|
| Continuous Glucose Monitor | <ul style="list-style-type: none"> For members with diabetes mellitus who often experience unexplained hypoglycemia or impaired awareness of hypoglycemia that puts them at risk or considered otherwise unstable. Covered per FDA age indications Devices that monitor glucose continuously. Other glucose monitors covered under FFS outpatient pharmacy benefit |
| Contraceptive Drugs and Devices or Birth Control | <ul style="list-style-type: none"> Covered as appropriate per FDA guidelines for age or other restrictions Services to aid members of childbearing age to voluntarily control family size or to avoid or delay an initial pregnancy Includes, but is not limited to: <ul style="list-style-type: none"> IUD and IUCD insertions, or any other invasive contraceptive procedures/devices Implantable medications Hormonal contraceptive methods - oral, transdermal, intravaginal, injectable hormonal contraceptives Barrier contraceptive methods – e.g., diaphragms/cervical caps Emergency contraceptives – e.g. Plan B and Ella Over the counter contraceptive medications – e.g., anything with a spermicide, prescription required for coverage under FFS |
| Cosmetic/ Reconstructive Surgery | <ul style="list-style-type: none"> Surgery to repair defects or injuries When required as the result of accidental injury or disease, or when performed to correct birth defects, such as cleft lip and palate |
| Dental Services | <ul style="list-style-type: none"> Services provided by a dentist, orthodontist, or oral surgeon |
| Durable Medical Equipment and Related Supplies | <ul style="list-style-type: none"> Devices and medical equipment prescribed by a physician to ameliorate disease, illness, or injury. For the initial purchase and reasonable replacement of standard implant and orthotic/prosthetic devices, and for the rental or purchase (at WVCHIP's discretion) of standard durable medical equipment, when prescribed by a physician For members who have received covered services from an out-of-state facility and require Durable Medical Equipment (DME)/medical supplies, Orthotics and Prosthetic devices and appliances, and other related services or items that are medically necessary at discharge, a written prescription by the respective out-of-state attending physician must be presented to a West Virginia provider for provision of services requested. This is required to assure the warranty is valid and to ensure that repairs and maintenance are provided in the most efficient and cost-effective means for WVCHIP members. Other DME policies apply |
| Emergency Outpatient Services and Supplies | <ul style="list-style-type: none"> Emergency outpatient services are covered Includes acute medical or accidental care provided in an outpatient facility, urgent care facility, or a provider's office |



| WVCHIP | Scope of Benefit |
|----------------------|---|
| Foot Care | <ul style="list-style-type: none"> • Foot care services • Includes medically necessary foot care performed by a health care provider practicing within the scope of his/her license, including such services as: <ul style="list-style-type: none"> ○ Treatment of bunions, neuromas, hammertoe, hallux valgus, calcaneal spurs or exostosis ○ Removal of nail matrix or root ○ Treatment of mycotic infections ○ Diabetic foot care (may include routine foot care) • Surgical procedures other than in office require prior authorization |
| Hearing Services | <ul style="list-style-type: none"> • Hearing exams and hearing aids • Includes annual examinations and medically necessary external hearing aids with prior authorization |
| HealthCheck | <ul style="list-style-type: none"> • Early and Periodic Screening, Diagnosis, and Treatment services (EPSDT). • This includes periodic, comprehensive health examinations; developmental delay, vision, dental, and hearing assessments; immunizations; and treatment for follow-up of conditions found through the health examination as covered by WVCHIP • HealthCheck requires standard health screening forms to be completed by providers at well-child exams. See dhhr.wv.gov/healthcheck/Pages/default.aspx for more information |
| Hemophilia Program | <ul style="list-style-type: none"> • WVCHIP has partnered with the Charleston Area Medical Center (CAMC) and West Virginia University Hospitals (WVUH) to provide quality hemophilia services at a reasonable cost to WVCHIP members. Members who participate in the program will be eligible for the following benefits: • An annual evaluation by specialists in the Hemophilia Disease Management Program which will be paid at 100% with no copay. (This evaluation is not intended to replace, or interrupt care provided by an existing medical home provider or specialists) • Hemophilia expenses, including factor replacement products, incurred at CAMC or WVUH will be paid at 100% with no copay after prior authorization. • Lodging and travel <ul style="list-style-type: none"> ○ Lodging expenses for child and 1 or 2 adults/guardians incurred to enable the member to receive services from the Hemophilia Disease Management Program. Lodging must be at an approved travel lodge and will be covered at 100% of charge ○ Travel expenses incurred between the member's home and the medical facility to receive services in connection with the Hemophilia Disease Management Program. Gas will be reimbursed at the federal rate for one vehicle. Reimbursement of meal expenses up to \$30 per day per person. Receipts are required for meal reimbursement ○ Submit receipts to The Health Plan |
| Home Health Services | <ul style="list-style-type: none"> • Intermittent health services of a home health agency when prescribed by a physician • Services must be provided in the home, by or under the supervision of a registered nurse, for care and treatment that would otherwise require confinement in a hospital or skilled nursing facility |



| WVCHIP | Scope of Benefit |
|--|---|
| Hospice Care | <ul style="list-style-type: none"> In-home care provided to a terminally ill individual as an alternative to hospitalization |
| Hyperlipidemia (High Cholesterol) Screening | <ul style="list-style-type: none"> WVCHIP, along with HealthCheck, has adopted the American Heart Association's (AHA) guidelines regarding blood cholesterol screening for all children and adolescents Beginning at age 2, WVCHIP recommends, but does not require, that all children and adolescents have a hyperlipidemia risk screening to determine their risk of developing high cholesterol. When one or more risk factors indicate the child is high risk, an initial measurement of total cholesterol can be obtained. Additional testing and follow-up should be based on total cholesterol levels, following the American Academy of Pediatrics' recommendations for cholesterol management |
| Immunizations for Children and Adolescents | <ul style="list-style-type: none"> Standard immunizations for children and adolescents. All age-appropriate vaccines through age 18 are covered as recommended by the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunizations. WVCHIP covers immunizations as part of an associated office visit to a doctor enrolled in the Vaccines for Children (VFC) program. See "Well Child Care" or the "Immunization Schedules" located at chip.wv.gov for more details. WVCHIP purchases vaccines from the State's VFC program. This program allows physicians to provide free vaccines to children. Members should receive vaccinations from providers that participate in this program Out-of-State vaccinations are not covered |
| Immunizations for Pregnant Members 19 and Over | <ul style="list-style-type: none"> Immunizations for pregnant women over age 19 The following immunizations will be covered for members enrolled in the Pregnant Women's Program, unless contraindicated per the immunization guidelines: hepatitis A, hepatitis B, herpes zoster, human papillomavirus, influenza (flu shot), measles, mumps, rubella, meningococcal pneumococcal, tetanus, diphtheria, pertussis, and varicella as recommended by the American Academy of Family Physicians |
| Inpatient Hospital and Related Services | <ul style="list-style-type: none"> Confinement in a hospital including semi-private room, special care units, and related services and supplies during confinement |
| Inpatient Medical Rehabilitation Services | <ul style="list-style-type: none"> Services related to inpatient facilities that provide rehabilitation services |
| Iron-Deficiency Anemia Screening | <ul style="list-style-type: none"> Anemia screening WVCHIP, along with HealthCheck, requires that all infants are tested (hemoglobin and/or hematocrit) for iron-deficiency anemia at 12 months of age. Providers are encouraged to screen all infants and children at each well-child exam visit to determine those who are at risk for anemia Those at high risk or those with known risk factors should be tested at more frequent intervals as recommended by the CDC This screening will also be covered as needed for pregnant women |



| WVCHIP | Scope of Benefit |
|--|---|
| Laboratory Services | <ul style="list-style-type: none"> Laboratory and x-ray services provided in a facility other than a hospital outpatient department Including, but not limited to, iron deficiency anemia, lead testing, complete blood count, chemistry panel, glucose, urinalysis, total cholesterol, tuberculosis, etc. |
| Lead Risk Screen | <ul style="list-style-type: none"> A lead risk screen must be completed on all children between the ages of 6 months and 6 years at each initial and periodic visit A child is considered high risk if there are one or more checked responses on the Lead Risk Screen and low risk if no responses are checked. Serum blood testing is required at 12 and 24 months and up to 72 months if the child has never been screened |
| Maternity Services WVCHIP under age 19 WVCHIP pregnant mothers over 19 | <ul style="list-style-type: none"> Maternal care services including global prenatal obstetrical care, delivery, and postpartum care service. WVCHIP pregnant mothers are only eligible for up to 60 days postpartum If a member is pregnant at the time of turning 19 and aging out of WVCHIP coverage, the member needs to contact DHHR to be evaluated for WVCHIP pregnancy coverage Maternity services for members who require more than 20 visits in 6 months will be covered with prior authorization. Coverage includes but is not limited to 2 ultrasounds during a pregnancy without prior authorization; testing for Down's Syndrome, Associated Protein Plasma-A, etc., with prior authorization; and inpatient stays for vaginal/cesarean delivery, breast pumps and breastfeeding education Sterilization is covered for members over 21 |
| Mental Health and Substance Use Disorder Services | <ul style="list-style-type: none"> Mental health services Substance use disorder services This may include evaluation, referral, diagnostic, therapeutic, and crisis intervention services performed on an inpatient or outpatient basis (including a physician's office) |
| MRA/ MRI | Magnetic Resonance Angiography (MRA) services <ul style="list-style-type: none"> Magnetic Resonance Imaging (MRI) services Requires prior authorization |
| Neuromuscular stimulators, bone growth stimulators, vagal nerve stimulators, and brain nerve stimulators | <ul style="list-style-type: none"> Stimulators for bone growth, neuromuscular, and vagal and brain nerves |



| WVCHIP | Scope of Benefit |
|--|--|
| Nutritional Counseling | <ul style="list-style-type: none"> Coverage is limited to 2 visits per year when prescribed by a physician for children with the following conditions: <ul style="list-style-type: none"> Diabetes, Type 1 and 2 Overweight and obesity with documentation of Body Mass Index (BMI) High cholesterol or other blood lipids High blood pressure Gastrointestinal disorders such as GERD or short gut syndrome Celiac disease Food allergies Failure to thrive or poor growth |
| Nutritional Supplements | <ul style="list-style-type: none"> When it is the only means of nutrition and prescribed by a physician or a prescription amino acid elemental formula for the treatment of short bowel or severe allergic condition that is not lactose or soy related |
| Oral Surgery | <ul style="list-style-type: none"> Only covered for extracting impacted teeth, medically necessary orthognathism (straightening of the jaw) and medically necessary ridge reconstruction |
| Organ Transplants | <ul style="list-style-type: none"> Organ transplants are covered when deemed medically necessary and non-experimental Fees/Expenses: WVCHIP will pay all covered expenses related to prior transplant, transplant, and follow-up services while the child is enrolled in WVCHIP. Testing for persons other than the chosen donor is not covered Travel Allowance: Because transplant facilities may be located some distance from the patient's home, benefits include up to \$5,000 per transplant for patient travel, lodging, and meals related to visits to the transplant facility or physician. A portion of this benefit is available to cover the travel, lodging and meals for a member of the patient's family or a friend providing support. Receipts are required for payment of this benefit. No alcoholic beverages will be reimbursed. Mileage will be reimbursed at the federal mileage rate for medical expenses. The travel allowance benefit applies only to services pertaining to the transplant |
| Orthodontia Services | <ul style="list-style-type: none"> Orthodontic services are covered if medically necessary for a WVCHIP member whose malocclusion creates a disability and impairs their physical development. Treatment is routinely accomplished through fixed appliance therapy and maintenance visits |
| Outpatient Diagnostic and Therapeutic Services | <ul style="list-style-type: none"> Laboratory and diagnostic tests and therapeutic treatments as ordered by a physician |
| Outpatient Hospital Services | <ul style="list-style-type: none"> Medical services furnished on an outpatient basis by a hospital, regardless of the type of provider ordering the service |
| Outpatient Therapy Services: PT, OT, ST, VT | <ul style="list-style-type: none"> Therapy services provided by physical therapists, occupational therapists, speech therapists and vision therapists Maintenance therapy Requires prior authorization 20 visits per calendar year |



| WVCHIP | Scope of Benefit |
|--|--|
| Pap Smear | <ul style="list-style-type: none"> Annual pap smear and the associated office visit to screen for cervical abnormalities |
| PET Scan | <ul style="list-style-type: none"> Photo Emission Topography scan Prior authorization required |
| Professional Services | <ul style="list-style-type: none"> Physician or other licensed provider for treatment of an illness, injury, or medical condition Includes outpatient and inpatient services such as surgery, anesthesia, radiology, office visits, and urgent care visits |
| Skilled Nursing Facility Services | <ul style="list-style-type: none"> Facility based nursing services to those who require twenty-four (24) hour nursing level of care Confinement in a skilled nursing facility including a semi-private room, related services, and supplies. Confinement must be prescribed by a physician |
| Sleep Apnea | <ul style="list-style-type: none"> Treatment for sleep apnea All sleep testing, equipment, and supplies are covered |
| Specialty Drugs (Physician Administered) | <ul style="list-style-type: none"> * Specialty drugs for acute and chronic diseases Acute and chronic diseases such as rheumatoid arthritis, anemia, cerebral palsy, hemophilia, osteoporosis, hepatitis, cancer, multiple sclerosis, and growth hormone therapy are examples of conditions that specialty medications are covered |
| Tobacco Cessation | <ul style="list-style-type: none"> THP is making tobacco cessation services available to members 18 and older for two 12-week cycles per lifetime. THP will provide 100% coverage for the tobacco cessation benefit for pregnant members during their pregnancy at 18 and older. Will cover an initial and follow-up visit to the member's physician or nurse practitioner at no cost to the member Prescription drugs and aides covered under FFS outpatient pharmacy benefit |
| Urgent Care & After-Hours Clinic Visits | <ul style="list-style-type: none"> A visit to an urgent care or after-hours clinic is treated as a physician visit for illness |
| Vision Services | <ul style="list-style-type: none"> Services provided by optometrists, ophthalmologists, surgeons providing medical eye care and opticians. Professional services, lenses including frames, and other aids to vision. Vision therapy Covered benefits include annual exams and eyewear. Lenses/frames or contacts are limited to a maximum benefit of \$125 per year. The year starts on the date of service. The office visit and examination are covered in addition to the \$125 eyewear limit |



| WVCHIP | Scope of Benefit |
|-----------------|--|
| Well Child Care | <ul style="list-style-type: none"> • A complete preventive care checkup includes, but is not limited to: <ul style="list-style-type: none"> ○ Height and weight measurement ○ BMI calculation ○ Blood Pressure Check ○ Objective vision and hearing screening ○ Objective developmental/behavioral assessment ○ Lead risk screen ○ Physical examination ○ Age-appropriate immunizations as indicated by physician • Wellness visits are covered at: <ul style="list-style-type: none"> ○ 3-5 days after birth ○ 1 month ○ 2 months ○ 4 months ○ Every 3 months from 6 to 18 months ○ 24 months ○ 30 months ○ 3 years old ○ 4 years old ○ Annually after age 4 to 18 years old • Objective– developmental screening tool is to be administered to child at the 9, 18, and 30 months well child visits • Objective– autism screening tool is to be administered to the child at the 18 and 24 months well child visits |

| WVCHIP Fee-For-Service Benefits | |
|--|--|
| Birth to Three (BTT) | This statewide system can assess early child development and provide services and support for the families of children three and under who have a delay in their development or may be at risk of having a delay |
| Outpatient Prescription Benefit Services | Mandatory generic substitution, including oral contraceptives |



WVCHIP Benefit Exclusions

Some services are not available through The Health Plan or WVCHIP. If a member chooses to get these services, the member may have to pay the entire cost of the service. The Health Plan is not responsible for paying for these services and others:

- Acupuncture
- All expenses incurred at a facility when a patient leaves against medical advice
- Ancillary services and/or services resulting from an office visit not covered
- Aqua therapy
- Autopsy and other services performed after death, including transportation of the body or repatriation of remains
- Behavioral or functional type skills training except for applied behavior analysis (ABA) treatment
- Biofeedback
- Coma stimulation
- Cosmetic or reconstructive surgery when not required as a result of accidental injury or disease, or not performed to correct birth defects; services resulting from or related to these excluded services
- Court-ordered services that are not covered benefits and not medically necessary
- Custodial care, intermediate care (such as residential treatment centers), domiciliary care, respite care, rest cures, or other services primarily to assist in the activities of daily living, or for behavioral modification, including applied behavior analysis (ABA), except to the extent ABA is mandated to be covered for treatment of Autism Spectrum Disorder by W.Va. Code §5-16-7(a)(8)
- Daily living skills training
- Dental services other than those listed as covered
- Duplicate testing, interpretation, or handling fees
- Education, training and/or cognitive services, unless specifically listed as covered services
- Elective abortions
- Electroconvulsive therapy
- Electronically controlled thermal therapy
- Emergency evacuation from foreign country, even if medically necessary
- Expenses for which the member is not responsible, such as patient discounts and contractual discounts
- Expenses incurred as a result of illegal action while incarcerated or while under the control of the court system
- Experimental, investigational, or unproven services
- Fertility drugs and services
- Foot care (routine, except for diabetic patients) including:
 - Removal in whole or in part: corns, calluses (thickening of the skin due to friction, pressure, or other irritation), hyperplasia (overgrowth of the skin), hypertrophy (growth of tissue under the skin)



- Cutting, trimming, or partial removal of toenails
- Treatment of flat feet, fallen arches, or weak feet
- Strapping or taping of the feet
- Genetic testing for screening purposes – except those tests covered under the maternity benefit are not covered; however, a prior authorization may be submitted for review and exceptions may be approved
- Glucose monitoring devices, except Accu-Check models covered under the prescription drug benefit
- Hearing aids implanted; external hearing aids are covered when prior authorized as medically necessary
- Homeopathic medicine
- Hospital days associated with non-emergency weekend admissions or other unauthorized hospital days prior to scheduled surgery
- Hypnosis
- Routine childhood immunizations from non-VFC providers
- Incidental surgery performed during medically necessary surgery
- Infertility services including in vitro fertilization and gamete intrafallopian transfer (GIFT), embryo transport, surrogate parenting, and donor semen, semen storage, any other method of artificial insemination, and any other related services, including workup for infertility treatment
- Maintenance outpatient therapy services, including, but not limited to:
 - Chiropractic treatment
 - Mental health services
 - Occupational therapy
 - Osteopathic manipulations
 - Physical therapy
 - Speech therapy
 - Vision therapy
 - Massage therapy
- Medical equipment, appliances or supplies of the following types:
 - Augmentative communication devices
 - Bariatric beds and chairs
 - Bathroom scales
 - Educational equipment
 - Environmental control equipment, such as air conditioners, humidifiers or dehumidifiers, air cleaners or filters, portable heaters, or dust extractors
 - Equipment or supplies which are primarily for patient comfort or convenience, such as bathtub lifts or seats, massage devices, elevators, stair lifts, escalators, hydraulic van or car lifts, orthopedic mattresses, walking canes with seats, trapeze bars, child strollers, lift chairs, recliners, contour chairs, and adjustable beds or tilt stands
 - Equipment and supplies which are widely available over the counter, such as wrist stabilizers and knee supports



- Exercise equipment, such as exercycles, parallel bars, walking, climbing or skiing machines
- Hygienic equipment, such as bed baths, commodes, and toilet seats
- Motorized scooters
- Nutritional supplements (unless it is the only means of nutrition or a prescription amino acid elemental formula for the treatment of short bowel or severe allergic condition that is not lactose or soy related), over-the-counter formula, food liquidizers or food processors
- Professional medical equipment, such as blood pressure kits or stethoscopes
- Replacement of lost or stolen items
- Standing/tilt wheelchairs
- Supplies, such as tape, alcohol, Q-tips/swabs, gauze, bandages, thermometers, aspirin, diapers (adult or infant), heating pads or ice bags
- Traction devices
- Vibrators
- Whirlpool pumps or equipment
- Wigs or wig styling
- Medical rehabilitation and any other services which are primarily educational or cognitive in nature
- Mental health or chemical dependency services to treat mental illnesses which will not substantially improve beyond the patient's current level of functioning
- Non-listed brand name drugs determined not medically necessary
- Non-enrolled providers
- Optical services: Any services not listed as covered benefits under Vision Services, including low-vision devices, magnifiers, telescopic lenses, and closed-circuit television systems
- Oral appliances, including but not limited to those treating sleep apnea
- Orientation therapy
- Orthotripsy
- Personal comfort and convenience items or services (whether on an inpatient or outpatient basis), such as television, telephone, barber or beauty service, guest services, and similar incidental services and supplies, even when prescribed by a physician
- Physical conditioning: Expenses related to physical conditioning programs, such as athletic training, body building, exercise, fitness, flexibility, diversion, or general motivation
- Physical, psychiatric, or psychological examinations, testing, or treatments not otherwise covered by WVCHIP, when such services are:
 - Related to employment
 - To obtain or maintain insurance
 - Needed for marriage or adoption proceedings
 - Related to judicial or administrative proceedings or orders
 - Conducted for purposes of medical research
 - To obtain or maintain a license or official document of any type
 - For participation in athletics
- Prostate screening, unless medically indicated



- Radial keratotomy, Lasik procedure and other surgery to correct vision
- Safety devices used specifically for safety or to affect performance, primarily in sports-related activities
- Screenings, except those specifically listed as covered benefits
- Service/therapy animals and the associated services and expenses, including training
- Services rendered by a provider with the same legal residence as a participant, or who is a member of the policyholder's family, including spouse, brother, sister, parent, or child
- Services rendered outside the scope of a provider's license
- Sex transformation operations
- Skilled nursing services provided in the home, except intermittent visits covered under the Home Health Care benefit
- Sensory Stimulation therapy (SS)
- Take-home drugs provided at discharge from a hospital
- Treatment of temporomandibular joint (TMJ) disorders, including intraoral prosthetic devices or any other method of treatment to alter vertical dimension or for temporomandibular joint dysfunction not caused by documented organic disease or acute physical trauma
- The difference between private and semiprivate room charges
- Therapy and related services for a patient showing no progress
- Therapies rendered outside the United States that are not medically recognized within the United States
- Transportation that is not emergent or medically unnecessary facility to facility transports, including
 - Transportation to any service not covered by The Health Plan
 - Transportation of members who do not meet the medical necessity requirements for level of service billed
 - Transportation provided when the member refuses the appropriate mode of transportation
 - Transportation to a service that requires prior authorization but has not been prior authorized
 - Reimbursement for ground or air ambulance mileage beyond the nearest appropriate facility
 - Transportation to the emergency room for routine medical care
- Weight loss, health services and associated expenses intended primarily for the treatment of obesity and morbid obesity, including wiring of the jaw, weight control programs, weight control drugs, screening for weight control programs, bariatric surgery, and services of a similar nature
- Work-related injury or illness

This is not a complete list of the services that are not covered by The Health Plan. If a service is not covered, not authorized, or is provided by an out-of-network provider, the member may have to pay.



Additional Resources for Mountain Health Trust Members

| Program | Description | MHT Population | Contact Information |
|---------------------------------------|--|----------------|---|
| Tobacco Cessation | <p>The Health Plan's nationally certified ALA (American Lung Association) tobacco cessation facilitator engages and educates the member to assist in developing a member specific tobacco quit plan.</p> <p>The program addresses:</p> <ul style="list-style-type: none"> • Developing a plan to quit • Getting support and encouragement • Learning new skills and behaviors • Getting medication, if necessary, to assist with quitting and how to take it correctly • Preparing for relapse and difficult situations | All | 1.888.613.8385 |
| Free Cell Phones for Medicaid Members | <p>THP has partnered with SafeLink to offer the LifeLine program to our members at no cost. Members receive:</p> <ul style="list-style-type: none"> • A smartphone with 1GB data and 1,000 monthly minutes • Unlimited text • Free calls to The Health Plan | Medicaid | <p>1.877.631.2550</p> <p>safelink.com</p> <p>Promo code: THPWV</p> |
| Non-Emergent Transportation | <ul style="list-style-type: none"> • Members with Medicaid may be eligible for transportation services • Members can contact NEMT broker to schedule a reservation | Medicaid | 1.844.549.8353 |
| Right From The Start Program (RFTS) | Statewide program that helps WV mothers and their babies lead healthier lives by offering home visitation services with a designated coordinator (RN or LSW) | All | wvdhhr.org/rfts |
| West Virginia Birth to Three Program | WV Birth to Three services are administered by the West Virginia Department of Health and Human Resources, Bureau for Public Health, Office of Maternal, Child and Family Health in cooperation with the Early Intervention Interagency Coordinating Council (ICC) | All | 1.304.558.5388 |



| Program | Description | MHT Population | Contact Information |
|--|--|----------------|-----------------------------------|
| Children with Special Healthcare Needs (CSHCN) | CSHCHN Program was created to assist families who have children with conditions that need special care | All | 1.304.558.5388 |
| Teladoc | 24/7/365 access to providers for non-emergent issues | All | 1.800.TELADOC (1.800.835.2362) |



Hours of Operation

Providers must ensure that the hours of operation for members are convenient, do not discriminate against members, and are no less than the hours of operation offered to commercial members or comparable to Medicaid fee for service. The provider must ensure that waiting times at sites of care are kept to a minimum and ensure that the waiting time standard for MHT members is the same standard used for commercial members. Providers cannot discriminate against MHT members in the order that patients are seen or in the order that appointments are given (providers are not permitted to schedule Medicaid-only days).

Cultural Competence

Mountain Health Trust (WV Medicaid/WVCHIP) providers are required to perform healthcare services in a culturally competent manner to all members. This includes members with limited English proficiency or reading skills, those with diverse cultural and ethnic backgrounds, the homeless, and individuals with physical and mental disabilities, regardless of sex, sexual orientation, or gender identity.

To ensure that providers provide services in a culturally competent manner, THP has developed training materials related to cultural competence and social determinants of health. The Cultural Competency/Social Determinants of Health Training for Providers PowerPoint presentation and attestation form may be accessed on THP's [provider portal](#) under "Resource Library," "Training and Education." Cultural competency training is noted by THP's Practice Management Consultants during provider on-site surveys. Practice Management Consultants will conduct provider training upon request.



HealthCheck (EPSDT)

Early and periodic screening, diagnosis, and treatment (EPSDT) are medically necessary services, including interperiodic and periodic screenings, listed in section 1905(a) of the Social Security Act. EPSDT entitles MHT-eligible infants, children, and adolescents to any treatment or procedure that fits within any of the categories of MHT-covered services listed in section 1905(a) of the Social Security Act if that treatment or service is necessary to "correct or ameliorate" defects and physical and mental illnesses or conditions.

EPSDT services should be provided to all children and young adults up to age 21. The provider should do the screening (periodic, comprehensive child health assessments) to all eligible members.

These should be regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth.

At a minimum, these screenings must include, but are not limited to:

1. A comprehensive health and developmental history (including assessment of both physical and mental health development)
2. An unclothed physical exam
3. Laboratory tests (including blood lead screening appropriate for age and risk factors);
4. Vision testing
5. Appropriate immunizations, in accordance with the schedule for pediatric vaccines established by the advisory committee on immunization practices
6. Hearing testing
7. Dental services (furnished by direct referral from a PCP to a dentist for children beginning six months after the first tooth erupts or by 12 months of age);The PCP must urge members to see their dental provider at least once every six (6) months for regular check-ups, preventive pediatric dental care, and any services necessary to meet the MEMBER'S diagnostic, preventive, restorative, surgical, and emergency dental needs.
8. Behavioral health screening; and
9. Health education (including anticipatory guidance).

It is important that the provider documents all the above on the member's chart as well as referrals. The provider should submit a 1500 claim form with the appropriate codes/modifiers for services rendered to The Health Plan for reimbursement. **The EP modifier must be billed on all EPSDT services.** EPSDT claims are paid without any coordination of benefits. Further information regarding EPSDT, current EPSDT forms and periodicity guidelines can be found on the following websites:

- dhhr.wv.gov/HealthCheck/providerinfo/Pages/default.aspx
- dhhr.wv.gov/bms/Pages/Chapter-519-Practitioner-Services.aspx

The Health Plan sends a monthly notice to the PCP with the list of his/her patients(s) that are expected to have a well-child exam during that month. If the member is not a patient of that PCP, the sheet should be returned to The Health Plan and marked accordingly in order to correct the records.

REMEMBER, THESE DATES ARE FOR WELL-CHILD EXAMS. If the provider does a well-child exam at the same time as a sick visit, please use the appropriate codes.

The Health Plan also sends a reminder notice to appropriate members each month that a well-child exam is due.



Medicaid Copays

Medicaid members have copays for some services. The following copays apply:

| Service | Tier 1 Up to 50% FPL | Tier 2 50.01 to 100% FPL | Tier 3 100.01% of FPL |
|--|-------------------------|-----------------------------|--------------------------|
| Inpatient hospital (acute care 11x) | \$0 | \$35 | \$75 |
| Office visit (physicians and nurse practitioners) (99201-99205, 99212-99215 only for office visits for new and established patients based on level of care) | \$0 | \$2 | \$4 |
| Non-emergency use of emergency department hospital only (Lowest level, 99282, of emergency room visits in hospitals. The definition of this visit is an emergency department visit for the evaluation and management of a patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision-making) | \$8 | \$8 | \$8 |
| Any outpatient surgical services rendered in a physician's office, ASC or outpatient hospital, excluding emergency rooms | \$0 | \$2 | \$4 |

Members and providers can access copay and member eligibility information through the WV Medicaid Fiscal Agents AVRS system by calling 1.888.483.0793.

Maximum Out-of-Pocket (OOP):

Each calendar year quarter, members will have a maximum out-of-pocket (OOP) payment. The OOP is the most the member will ever be required to pay in any given quarter regardless of the number of health care services received. The following table shows the OOP for each tier level.

| Tier Level | Out-of-Pocket Maximum |
|---------------------------|-----------------------|
| 1 (Up to 50% FPL) | \$8 |
| 2 (50.01 - 100% FPL) | \$71 |
| 3 (100.01% FPL and above) | \$143 |

Calendar quarters are as follows:

January 1 – March 31
April 1 – June 30
July 1 – September 30
October 1 – December 31



Copayment Exemptions

As of January 1, 2014, some individuals who receive Medicaid services will be expected to pay copayments for certain services.

Exempt from the copayment requirements are:

- Behavioral health
- Pregnant women, including pregnancy-related services up to 60 days post-partum
- Children under age 21, and
- Native American and Alaska natives.

Services exempt from copayment include:

- Long term care
- Hospice
- Medicaid waiver
- Breast and Cervical Cancer Treatment Program
- Family planning, and
- Emergency services

Copayments are based on the member's level of income and may not exceed 5% of the member's household income. Providers may not deny services to individuals whose income falls below 100% of the federal poverty level due to their inability to make a copayment.

Medicaid Prescription Benefit

Pharmacy services for WV Medicaid managed care organization (MCO) members are administered by the traditional fee-for-service pharmacy program. All prescriptions should be billed with the information below:

- BIN 610164
- PCN DRWVPROD

Questions regarding claims processing should be directed to the Medicaid Fiscal Agent's POS Pharmacy Help Desk at 1.888.483.0801. Vendor specification document can be found on the West Virginia Medicaid Management Information System [website](#) for further information regarding claims processing.



WVCHIP Copays

WVCHIP members participate in some level of cost sharing (copayments and premiums), except for those children registered under the federal exception for Native Americans or Alaskan Natives.

There are no copayments for maternity services or pregnant women over 19 years of age.

WVCHIP has three enrollment groups in the plan. Each enrollment group has a different level of cost sharing.

| Medical Services and Prescription Benefits | WVCHIP Gold | WVCHIP Blue | WVCHIP Premium |
|---|------------------|------------------|---|
| Generic Prescriptions | No copay | No copay | No copay |
| Listed Brand Prescriptions | \$5 | \$10 | \$15 |
| Non-listed Brand Prescriptions | Full retail cost | Full retail cost | Full retail cost |
| Multisource Prescriptions | No copay | \$10 | \$15 |
| Primary Care Physician Medical Home Physician Visit | No copay | No copay | No copay |
| Physician Visit (non-medical home) | \$5 | \$15 | \$20 |
| Preventive Services | No copay | No copay | No copay |
| Immunizations | No copay | No copay | No copay |
| Inpatient Hospital Admissions | No copay | \$25 | \$25 |
| Outpatient Surgical Services | No copay | \$25 | \$25 |
| Emergency Department (waived if admitted) | No copay | \$35 | \$35 |
| Vision Services | No copay | No copay | No copay |
| Dental Benefit | No copay | No copay | \$25 copay for some non-preventive services |

Note: Copayments are waived for all office visits to member's medical home.



Out of Pocket Maximums

The maximum copayment amounts applied during a benefit year are as follows:

| # of Children Copay Maximum | WVCHIP Gold | WVCHIP Blue | WVCHIP Premium |
|--|----------------|----------------|------------------|
| 1 Child Medical Maximum | \$150 | \$150 | \$200 |
| 1 Child Prescription Maximum | \$100 | \$100 | \$150 |
| 2 Children Medical Maximum | \$300 | \$300 | \$400 |
| 2 Children Prescription Maximum | \$200 | \$200 | \$250 |
| 3 or more Children Medical Maximum | \$450 | \$450 | \$600 |
| 3 or more Children Prescription Maximum | \$300 | \$300 | \$350 |
| Dental Services | Does not apply | Does not apply | \$150 per family |

WVCHIP Prescription Benefit

Pharmacy services for WVCHIP managed care organization (MCO) members are administered by the traditional CHIP pharmacy program. All prescriptions should be billed with the information below:

- BIN 004336
- PCN ADX
- RX Group RX0243

Questions regarding claims processing should be directed to 1.800.364.6331.



Mountain Health Trust Out-of-Network Non-Patient Facing Provider Reimbursement

Effective August 1, 2019, services rendered by out-of-network non-patient facing providers will only be reimbursed if an authorization is obtained prior to the service being conducted.

Reimbursement for services prior authorized to out-of-network non-patient facing providers will be at 80% of the current MHT fee schedule.

Failure to obtain prior authorization for any service performed by an out-of-network non-patient facing provider will result in claim denial.

Under federal law and WV State code, the MHT program prohibits balance billing by all practitioners, regardless of location. All out-of-network practitioners' claims for providing non-emergency medical services will be denied unless the services have been prior authorized.

Emergency out-of-network MHT-covered services are eligible for reimbursement. The documentation provided with the claim must clearly indicate an emergency situation existed.

The Health Plan may pay for covered services due to out-of-network hospital transfers if:

- Medically necessary services are not available in plan.
- WV Medicaid members are traveling outside the state and need emergency medical treatment.
- Services have been pre-approved by The Health Plan.

For documented emergencies, the member may be admitted without prior approval in-network or out-of-network, but the request for authorization and documentation must be submitted within 24 hours of admission.

WVCHIP Emergency Services by Non-Participating Providers

Covered Emergency Services by non-participating providers shall be subject to the minimum payment rate requirements paid by the WVCHIP fee-for-service program.



Family Planning

Family planning services may be obtained by a Mountain Health Trust member without a referral or prior authorization through any MHT family planning provider, regardless of if they are in The Health Plan network or not. Family planning services are defined as those services provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy.

These services include:

- Health education and counseling necessary to make informed choices and understand contraceptive methods
- History and physical exam
- Pap smear and lab tests if medically indicated as part of the decision-making process for choice of contraceptive methods
- Diagnosis and treatment of sexually transmitted diseases (STD) if medically indicated
- Screening, testing, and counseling of at-risk individuals for human immunodeficiency virus (HIV) and referral for treatment
- Follow-up and care for complications associated with contraceptive methods issued by the family planning provider
- Provisions for contraceptive pills, devices, and supplies (Depo-Provera injections are permissible, prescriptions are to be issued for contraceptive pills)
- Tubal ligation and vasectomies (consent forms required)
- Pregnancy testing and counseling
- Family planning provided at postpartum visits and/or discharge post-delivery (postpartum care should be provided within eight weeks of delivery)

Local Health Departments

The Health Plan contracts with local West Virginia Health Departments to provide certain services for the MHT programs without a referral. These services include:

- All sexually transmitted disease (STD) services including screening, diagnosis, and treatment
- HIV services including screening and diagnostic studies
- Tuberculosis services including screening, diagnosis, and treatment
- Childhood immunizations
- Family planning
- HealthCheck

The Health Department should forward all records to the member's PCP and/or OB/GYN provider.

Environmental lead assessments for THP children with elevated blood levels will be reimbursed directly by the State Bureau for Public Health. THP is responsible for the blood lead screenings.



Staffing

Staffing for the MHT program consists of senior management, claims and customer service managers, an appeals coordinator, customer service representatives and claims analysts. The vice president is responsible for coordinating programs between The Health Plan and BMS/WVCHIP to assure compliance with the program, as well as ongoing education to Mountain Health Trust members.

There are outreach representatives who are under the direct supervision of the director. The outreach representatives are responsible for ongoing education of MHT members.

The Health Plan will ensure that follow-up and outreach contacts are initiated for missed appointments and failure to follow medical treatment plans.

A provider should notify The Health Plan that a member is not keeping scheduled appointments, not following the medical treatment plan, the member's behavior in the waiting room was inappropriate, or any other reason in which the member could benefit from redirection of behavior. The provider should document their chart accordingly. This documentation should be provided to The Health Plan after a member misses a second appointment.

Outreach representatives will then contact the member to discuss the situation, suggest alternate methods, and otherwise educate, especially to follow the provider's treatment plan. If transportation is a problem, members should be referred to the state's transportation vendor for non-emergency transportation assistance. The member needs to understand that the provider can ask for his/her removal from his/her roster if this noncompliance persists. Please call the Outreach Department at 1.855.577.7124 for an outreach representative to educate the member about these issues.

MHT members are continually educated about appropriate use of the emergency room. If members present to the ER for non-emergency cases, they may be responsible for the cost of the ER visit or a copay. The PCP should be contacted first for instructions, day or night. If it is a life-threatening situation, the member can call 911 or go to the closest ER but still call the PCP and The Health Plan within 48 hours after going to the ER. Follow-up care and treatment, including the removal of stitches, casts, and dressings must be given or arranged by the PCP.

Surgical Consent Forms

The Health Plan, in accordance with the WV Medicaid guidelines, will continue to require the completion of the state surgical consent forms for the following procedures:

- Hysterectomy
- Voluntary sterilizations (male or female)
- Pregnancy termination

The surgical consent forms for voluntary sterilizations must be completed and signed by the Medicaid member 30 days prior to the surgery. The consent form is valid for 180 days. Please note that none of the consent forms need to be submitted to The Health Plan but should remain with the member's medical records.

Effective July 1, 2020, THP shall make payment for tubal ligation without requiring at least 30 days between the date of informed consent and the date of the tubal ligation procedure.



Pregnancy and Newborn Enrollment

In accordance with the state of West Virginia requirements to effectively monitor and/or provide appropriate intervention during the member's antepartum, delivery, and postpartum period, The Health Plan has elected to adopt the state's guidelines. The Health Plan will continue to require all providers rendering services for antepartum care to submit the appropriate code for each encounter during the antepartum period that will be separately reimbursed. The Health Plan will also require separate billing for the delivery and postpartum services by submitting the appropriate CPT code(s).

The Health Plan requires the completion of the prenatal risk screening instrument (PRSI) upon the initial encounter when the EDC date is determined for all MHT members receiving maternity services. Physicians are asked to complete the prenatal risk screening form and fax it to The Health Plan at 740.695.5297 or complete the prenatal risk screen form located on the Provider website.

The most recent version of the PRSI is available [here](#) and can be found on the WV DHHR's Office of Maternal, Child and Family Health [website](#).

Based on this screening tool, members are contacted to begin tracking their pregnancy. An initial prenatal care visit must be scheduled within 14 days of the date on which a MHT woman is found to be pregnant. Any member who has a high-risk pregnancy will be referred to the prenatal care coordinators who are nurses with obstetrics experience. If the member smokes, she is also referred to the tobacco cessation program. Outreach representatives monitor the low-risk pregnancies on a trimester basis. Members are encouraged to participate with the Women, Infant, and Children's (WIC) program.

When The Health Plan MHT member gives birth, her newborn(s) is automatically covered from date of birth. The enrollment specialist calls new mothers in the hospital to enroll the newborn(s) into The Health Plan. The new mother is reminded to apply for an SSN for the newborn and to select a PCP for the baby. The importance of well-child visits and immunizations are stressed. The new mother will receive a newborn packet from The Health Plan along with the baby's ID card.

Members are encouraged to sign the baby up for the WIC program. The Health Plan ID card with the PCP listed is sent to the newborn. There is a process in place to get the newborn an ID number within 30 days. If a member needs a newborn's ID number, please call 1.855.577.7124, but please allow 10 business days from the baby's birth.

The new mother is also reminded of the importance of her own postpartum checkup that should occur within eight weeks of delivery. The outreach representative makes a postnatal follow-up call. She also does an initial newborn follow-up at that time. During the postnatal contact, the Edinburgh postnatal depression scale (EPDS) is reviewed for postpartum depression. If the member has a high score, she is referred to The Health Plan prenatal care coordinators who notify the member's OB provider.

Members can qualify for THP's postnatal incentive plan by going to their postnatal appointment within 7-84 days after delivery.



Women's Access to Health Care

In accordance with the Women's Health and Cancer Rights Act of 1998, The Health Plan covers reconstructive surgery after a mastectomy under the same terms and conditions as other regular inpatient services under the Plan, and will include:

- Coverage for reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Coverage for prostheses and physical complications of all stages of the mastectomy, including lymph edema.

This is all handled in a manner determined in consultation with the attending physician and the patient and approved by The Health Plan as medically necessary and appropriate.

The Health Plan allows women to have direct access to a range of women's health care providers, including obstetricians/gynecologists, advanced nurse practitioners, certified nurse midwives, and physician assistants. *This information is disclosed to members in the Member Handbook.*

An annual pap test and physical breast exam is encouraged for each member and may be done by the PCP and/or OB/GYN.

Tobacco Cessation

Members are encouraged to participate in The Health Plan's sponsored tobacco cessation classes **free of charge**. A staff member will provide the member with one-on-one personal support that can help him/her quit.

Diabetes

Insulin pumps are covered in specific medical cases. Diet management and education are covered as part of the diabetes disease management program. Blood glucose monitors are covered for members who are diabetic when a participating provider writes the order, and the monitor is obtained from a participating provider.

Members with diabetes should have an annual health assessment, dilated eye exam, kidney testing, and fasting lipid profile. Quarterly visits are encouraged for foot exams, HbA1c, blood pressure, and diabetes education. The Health Plan sends members with diabetes a yearly coupon as a reminder to have the dilated eye exam.



Medicaid Behavioral Health Services

THP is required to provide behavioral health services as outlined in the Bureau for Medical Services (BMS) provider manual to WV Medicaid members enrolled with THP. BMS' provider manual may be accessed on the [WV DHHR website](#).

The following chapters of the manual provide detailed information regarding services typically provided by behavioral health providers:

- Chapter 503: Licensed Behavioral Health Centers
- Chapter 504 Substance Use Disorders Services
- Chapter 510 Hospital Services
- Chapter 519: Practitioner Services
- Chapter 521: Behavioral Health Outpatient Services
- Chapter 522: Federally Qualified Health Centers and Rural Health Centers Services
- Chapter 523: Targeted Case Management and
- Chapter 531: Psychiatric Residential Treatment Facilities for Children Under 21

Note that while THP will cover behavioral health services as required by BMS, THP and BMS may have differing prior authorization requirements. Please refer to THP's website for our behavioral health payment policy.

Contact THP's Clinical Services Department at 1.877.221.9295 with questions or to obtain prior authorization for services.

WVCHIP Behavioral Health Services

Behavioral Health Services

WVCHIP members do not need a referral for behavioral health services. Member Services can help families, primary care providers, or members to locate behavioral health providers in their area.

Contact THP's Clinical Services Department at 1.877.221.9295 with questions or to obtain prior authorization for services.

Hours of Operation are Monday – Friday, 8 a.m. to 5 p.m.

The Health Plan provides inpatient acute psychiatric care and outpatient behavioral health services to CHIP members. This benefit includes acute inpatient psychiatric care, outpatient mental health services, outpatient substance use (alcohol and drugs) services, and Applied Behavior Analysis. All providers must be fully licensed and credentialed with THP to provide services to CHIP members.

Some services may require prior authorization. Please review the WVCHIP Behavioral Health Payment Policy located on the THP website.



Behavioral Health Services Not Covered:

- Services provided to individuals under the age of 21 performed in a children's psychiatric residential treatment facility (PRTF)
- Any services that are covered by fee-for-service
- School-based services
- Substance Use Disorder residential services
- Children's Residential Treatment
- H Codes (except H0031 for autism)

If there is a mental health or substance use emergency, please call 911 right away.

Court Ordered Services

Medically necessary court ordered treatment services are covered by The Health Plan. Court ordered services are subject to WVCHIP medical necessity reviews and determination.

Mountain Health Trust Behavioral Health Credentialing and Billing Guidelines

The Health Plan requires credentialing of all licensed behavioral health practitioners operating within a physician's practice except LGSWs and LCSWs operating under the guidance of a medical professional (Medicaid) or unlicensed individuals operating in an Office Based medication assisted treatment program (see below).

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 (Please see below for exceptions for OBMAT). THP will only reimburse supervised psychologists when providing services to our Medicaid members. A supervised psychologist must appear on the web page of the Board of Examiners of Psychologists in WV found [here](#).

All providers must be fully licensed and credentialed with THP to provide services to CHIP members.

Please note that this guideline does not apply to physician's offices within Licensed Behavioral Health Centers. Although the billing procedures described below do not apply to FQHC/RHC, the requirement for credentialing does apply to these agencies.

Also note that The Health Plan, in conformity with Mental Health Parity rules, does not require pre-authorization for clinic-based behavioral health outpatient services. Our authorization list is available on our [corporate website](#) in the "For Providers" section.

The Health Plan defaults to CMS policy as interpreted for Medicare for our Commercial plans unless the plan description specifies otherwise. If there is a question regarding this, please contact THP's Customer Service Department at 1.800.624.6961.



Medicaid

Chapter 519.2 and Chapter 521 of the Bureau for Medical Services (BMS) provider manuals clearly describe the circumstances under which a licensed behavioral health practitioner may provide services under the auspices of a physician's practice (again, these rules do not apply to physicians or practitioners employed by a licensed behavioral health center or an FQHC/RHC). The chapters are available on the WV DHHR's [website](#). **For the purpose of this section only, physician is understood to include physician extenders such as APRN and PA.**

Note that there is an exception, described below, for Office Based Medication Assisted Treatment programs properly certified/registered with the Office of Health Facility Licensure and Certification. This exception will be detailed below and applies only to members with Medicaid coverage/benefits.

Physicians may have appropriately licensed behavioral health staff working under them to provide behavioral health services which include the following: Licensed Professional Counselor (LPC), Licensed Independent Clinical Social Worker (LICSW), Licensed Certified Social Worker (LCSW), Licensed Graduate Social Worker (LGSW), Supervised Psychologist and Licensed Psychologist (LP).

BMS does not specify that a licensed behavioral health practitioner must practice under the supervision of a psychiatrist, nor does it make any statement about the scope of practice of the supervising physician.

The following staff may bill for behavioral health services in a medical clinic setting:

- Licensed Psychologist
- Advanced Practice Registered Nurse
- Physician Extender
- Supervised Psychologist officially approved by the WVBOP
- LICSW
- LCSW
- LGSW
- Licensed Professional Counselor

Medicaid requires that all staff with the exception of the LCSW and the LGSW bill under their own rendering NPI, using the appropriate CPT code without a modifier.

Please note OBMAT exception below. Therefore, all staff other than the LCSW and the LGSW must be credentialed with THP before they can bill for services. The LCSW and LGSW may bill under the physician's NPI with an AJ modifier on the CPT code and do not need to be credentialed by THP. Currently, the reimbursement level for modified and non-modified CPT codes is almost identical in most cases.

Office Based Medication Assisted Treatment (OBMAT) programs (applies to WV Medicaid only): In those OBMAT programs that are properly certified/registered with the Office of Health Facility Licensure and Certification (OHFLAC) the following staffing requirements/permissions will apply. **These individuals may bill under the physician's NPI using the AJ modifier so long as the appropriate supervision requirements are met:**



Staff Credentials

The following are the minimum supervision requirements per degree/credential type:

- Bachelor's Degree in Human Services without Alcohol and Drug Counselor Credential*: Indirect supervision required by Clinical Supervisor, Advanced Alcohol and Drug Counselor, Certified Clinical Counselor, Master Addiction Counselor, Licensed Psychologist, Licensed Professional Counselor, or Licensed Independent Clinical Social Worker.
- Master's Degree Only, includes Licensed Clinical Social Worker and Licensed Graduate Social Worker*: Indirect supervision required by Clinical Supervisor, Advanced Alcohol and Drug Counselor, Certified Clinical Counselor, Master Addiction Counselor, Licensed Psychologist, Licensed Professional Counselor, or Licensed Independent Clinical Social Worker.
- Doctoral Level, Non-Licensed*: Indirect supervision required by Clinical Supervisor, Advanced Alcohol and Drug Counselor, Certified Clinical Counselor, Master Addiction Counselor, Licensed Psychologist, Licensed Professional Counselor, or Licensed Independent Clinical Social Worker.

The following providers do not require supervision but will require credentialing with THP and therefore must bill as rendering provider. They may not bill under the physician's NPI:

- Licensed Independent Clinical Social Worker
- Licensed Psychologist
- Supervised Psychologist listed as such on the Board of Examiner's [website](#)
- Licensed Professional Counselor
- National Certified Addiction Counselor II as defined by NAADAC
- Master Addiction Counselor as defined by NAADAC
- Bachelor's Degree in Human Services with Alcohol and Drug Counselor Credential The WV Medicaid manual cites the following behavioral health codes as available with an AJ modifier: 90832, 90834, 90837, 90853, H0031 and 90847.

The Health Plan payment, authorization and approval methodologies conform to BMS requirements as stated in the manuals.

The Health Plan utilizes the following methodology for applications for credentialing all providers: WV Standardized Credentialing Application found on [CAQH](#) or [WV Department of Insurance](#).

Be aware that this will require that the rendering provider have an individual National Provider Identification Number (NPI). A provider may obtain an NPI number on the [NPPES website](#).

Should you have any questions regarding these instructions please feel free to contact the customer service department at 1.888.613.8385 or your practice management consultant. Contact information for the practice management consultant assigned to your county is available on our [website](#).

Providers should be aware that commercial and self-insured policies may vary. Please call our customer services line at 1.877.221.9295 should there be questions regarding these types of policy coverages.

The Health Plan will conduct routine post payment reviews on billings described above. Providers suspected of improper billing may be subject to requests for prior authorization in future and/or may be reported to The Health Plan's Special Investigations Unit for fraud, waste, and abuse. New network providers may be requested to submit planned procedures for prepayment review. All out of network providers are required to submit all procedures for prior authorization.



Medicaid Adult Dental

Dental Services: Adults age 21 and over

West Virginia Medicaid members age 21 and over qualify for \$1,000 in preventive and restorative dental care. Any amount over \$1,000 is the responsibility of the member. Providers may only bill members using the Medicaid fee schedule for any services rendered that exceed \$1,000.

Skygen USA is The Health Plan's administrator for this benefit and providers must contract with them to provide services to our members. Providers should call 1.888.983.4690. If you would like a copy of Skygen USA's Provider Manual, please visit skygenusa.com.

In addition, members have access to emergent procedures to evaluate and treat fractures, reduce pain, or eliminate infection (no financial cap). Specifically, fractures of the mandible and maxilla, biopsy, removal of tumors, and emergency extractions. Skygen will also cover these services on behalf of THP.

For a list of codes available under each benefit, 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. Please contact Skygen for a complete listing of codes requiring authorization, as well as any documentation requirements.

Dental services in a hospital setting

All procedures provided by a dentist or oral surgeon in a hospital setting requires a prior authorization. Refer to the [BMS website](#) for covered codes for adult dental over the age of 21.



Medicaid Children's Dental

Children's dental services (up to age 21) are covered by the managed care organization. Skygen USA is The Health Plan's administrator and providers must contract with them to provide services to our members. Providers should call 1.888.983.4690. If you would like a copy of Skygen USA's Provider Manual, please visit skygenusa.com.

Unlisted Procedure Code 41899

For members under the age of 21 that require dental services to be rendered in a hospital setting, the dental provider is required to obtain a prior authorization from Skygen USA for the procedure. Once the provider obtains the prior authorization from Skygen USA, the hospital services are required to be authorized through The Health Plan. Providers will need to contact THP's Customer Service Department at 1.888.613.8385 to obtain the prior authorization. The authorization number from Skygen USA will be required when requesting the authorization from THP.

Oral Health Fluoride Varnish Program

Primary care providers may receive a reimbursement for fluoride varnish application.

- Fluoride varnish is reimbursable to both **medical and dental** providers:
 - May be billed two times/year for each type of provider = four fluoride varnish treatments/year
 - Patient must be under 21 years old
 - Code may only be billed once within a six-month period per each type of provider
- **Medical Providers**
 - Bill procedure code 99188
 - Apply during time of well-child visit or health screening
 - Oral health risk assessment should be conducted prior to application
- **Dental Providers**
 - Bill procedure code D1206
 - Provide service at a dental visit
- **Topical application of fluoride** (excluding fluoride varnish)
 - Bill procedure code D1208
 - **CANNOT** bill D1206 with D1208

Additional information regarding this program is on the [BMS website](#).



Immunization Registry

There is a West Virginia statewide immunization information system (WVSIS) for all children, adolescents, and adults. WVSIS is a confidential, computerized information system that keeps complete and up-to-date shot records. Children often receive shots from several providers that can make the immunization record fragmented, causing missed doses or over immunization. The benefits of this registry are access to a current immunization record, better patient care, and higher immunization rates and less disease.

Childhood and adolescent immunization reviews should be done at well-child visits as well as during urgent problem-oriented visits.

For more information about this registry please call 1.877.408.8930 or visit the website at wvimm.org/wvsis.

Appeals and Grievances

This section outlines the information provided to Mountain Health Trust members regarding the right to file a complaint, grievance, or appeal.

Complaints and Grievances

- The member can file a complaint, also called a grievance, at any time.
- If a member is unhappy with something that happened while receiving health care services, the member can file a complaint or grievance. Examples of why a member might file a complaint or grievance include:
 - The member feeling they were not treated with respect
 - Unsatisfied with the health care received
 - It took too long to get an appointment
 - Disagreement with a decision that we made
- To file a complaint or grievance, the member should call The Health Plan at 1.888.613.8385 (TTY:711)
- To file a complaint or grievance in writing, the member may fax it to The Health Plan at 1.888.450.6025 or mail it to 1110 Main Street, Wheeling, WV 26003
- The member will need to send us a letter that has:
 - Name
 - Mailing address
 - The reason for filing the complaint and what the member wants The Health Plan to do
 - The doctor or authorized representative can also file a complaint or grievance for the member.

We will let the member know when we receive the complaint or grievance. A member can file a complaint or grievance at any time after the event about which the member is unhappy. The Health Plan will conduct a full investigation. We will usually give a decision within 30 calendar days and no later than 90 calendar days but may ask for extra time to give an answer.

The Health Plan will provide translation services, as needed, at no cost to the member.



Appeals

If a member believes his or her benefits were unfairly denied, reduced, delayed, or stopped, the member has the right to file an appeal with The Health Plan.

- To file an appeal, the member can call The Health Plan at 1.888.613.8385.
- To file an appeal in writing, the member will need to fax it to The Health Plan at 1.888.450.6025 or mail it to 1110 Main Street Wheeling, WV 26003.
- The member will need to send us a letter that has:
 - Member name
 - Provider's name
 - The date of service
 - Member mailing address
 - The reason why we should change our decision
 - A copy of any information that supports the appeal, such as written comments, additional documents, records, or information related to the appeal
 - A doctor or authorized representative can also file an appeal for the member. THP will not take punitive action against providers who request an expedited resolution or support a member's appeal

If a member calls and gives an appeal over the phone, The Health Plan will acknowledge the appeal in a letter.

A member must file an appeal within sixty (60) calendar days from the date on the notice of action from The Health Plan.

We will let the member know when we have received the appeal. The member can get copies of documents, records, and information about the appeal for free. Information may include medical necessity criteria, and any processes, strategies, or evidence-based standards used in setting coverage limits. A Committee will look at the appeal. None of the people on the Appeal Committee will have been involved in our initial decision to not authorize or pay for the health services. If the appeal involves a medical issue, the Committee will also talk to a health care professional who has the appropriate training and experience in the field of medicine necessary for making the decision on the medical issue. We have provided the titles and qualifications of individuals who may participate in the appeal decision review.

- Medical Director – board-certified practitioners (radiology, behavioral health, obstetrics/gynecology, general surgeon with current state licensures)
- Nurse Navigators – registered nurses with current state licensures.

The Health Plan must process and provide notice regarding the appeal within thirty (30) calendar days.

If The Health Plan needs more information for the appeal, or if the member wants to provide more information, the member or The Health Plan can ask for fourteen (14) more calendar days to finish the appeal. If The Health Plan decides to extend the review time to finish the appeal, the member will be notified in writing within two (2) calendar days.



Fast Appeals

If an appeal is about our decision to not approve or pay for some or all health care services, and the member needs an appeal decision fast, the member can ask for a fast appeal by calling The Health Plan at 1.888.613.8385. A fast appeal must be written within (60) calendar days. If we allow a fast appeal, we will schedule a meeting with the Committee no later than forty-eight (48) hours after we get the appeal. We will call the member twenty-four (24) hours after we get the appeal to let the member know the date, time, and place of the meeting. We will decide on the appeal no later than seventy-two (72) hours after receipt. If The Health Plan determines that an appeal is not a fast appeal, The Health Plan will provide the fast appeal request to the State so that they can determine a timeframe for resolution. The member will get a written notice explaining the next steps in the process.

To file a fast appeal, the member will need to provide us with:

- Member name
- Provider's name
- The date of service
- Member mailing address
- The reason why we should change our decision
- A copy of any information supporting the appeal, such as written comments, additional documents, records, or information related to the appeal

A member can file a Fast Appeal by either calling us, or mailing or faxing the information to:

The Health Plan
1110 Main Street
Wheeling, WV 26003
Phone Number: 1.888.613.8385
Fax: 1.888.450.6025

If we decide the appeal is not a fast appeal, we will handle the appeal like the normal appeals described in the section above. The member has the right to file a grievance if unhappy with the decision to deny the fast appeal.



State Fair Hearing Process

If a member is not happy with The Health Plan's appeal decision, and the appeal is about our decision to deny, reduce, change, or terminate payment for health care services, a member can request a State Fair Hearing. A member can only request a State Fair Hearing if it relates to a denial of a service, a reduction in service, termination of a previously authorized service, or failure to provide service timely. The member will get a notice mailed within thirteen (13) calendar days before any action is taken. The member must request a State Fair Hearing within 120 calendar days from the notice of appeal resolution from The Health Plan. The member may also request a State Fair Hearing if The Health Plan does not meet the timeframe for deciding on the appeal.

Send requests for State Fair Hearing to:

| Medicaid State Fair Hearing | WVCHIP State Fair Hearing |
|---|--|
| Bureau for Medical Services Office of Medicaid Managed Care 350 Capitol Street, Room 251 Charleston, WV 25301-3708 | Bureau for Medical Services Attn: WV Children's Health Insurance Program Room 251, 350 Capitol Street Charleston, West Virginia 25301 |

The Bureau for Medical Services/WVCHIP decision will be sent to the member in writing.

The Health Plan will continue benefits during the time of an appeal process or State Fair Hearing when:

- The member or provider on a member's behalf file an appeal on a timely basis
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment
- The services were ordered by an authorized provider
- The original period covered by the original authorization has not expired, and
- The member requests an extension of benefits within thirteen (13) days of The Health Plan determination.

To request an extension of benefits, call 1.888.613.8385. The Health Plan will pay for the services in question when the result of the appeal is to overturn the original decision. The Health Plan will pay for some or all the services as determined by the final appeal decision. If the result of the appeal is to uphold the original decision to deny, reduce, change or end payment for services, The Health Plan may take back the money that was paid for the services while the appeal was in process, and the member will be responsible for paying for the services.

Keeping Grievances and Appeals

The Health Plan will keep copies of member grievance and appeals documents, records and information about the grievance and appeal for review for ten (10) years.

Provider Reconsideration (Appeal)

If a provider does not agree with the decision made by The Health Plan, they have the right to file a reconsideration. Providers are limited to one level of reconsideration/appeal. A provider has the greater of 180 days from The Health Plan's denial or 180 days from the date of service to request a reconsideration.



Mountain Health Trust Statement of Members' Rights

- Receive information about The Health Plan, its services, practitioners, and your rights and responsibilities according to contract standards. We will provide this information upon enrollment, annually, and at least 30 days prior to any change. The Health Plan will provide all information according to the requirements of state law and the contract. Please see the benefit grid for covered services according to the contract.
- Be able to request and receive your medical records, and to request they be amended or corrected and receive prompt action in a timely manner of no later than 30 days from receipt of the request for records and no later than 60 days from the receipt of a request for amendments.
- Know you have the right to privacy and confidentiality regarding your personal information. Information about your medical history and enrollment file is private. You have the right to approve or refuse the release of personal information by The Health Plan, unless the law or this agreement requires it.
- Be able to discuss appropriate or medically necessary treatment options for your condition(s) with your practitioner, even if they are not covered by The Health Plan. However, if you or your practitioners prefer a certain treatment and it is not covered by The Health Plan, you could be responsible for the cost. This information will be presented in a manner appropriate to the member's condition and ability to understand. Your appropriate behavior, such as keeping appointments, helps in this decision-making. However, this does not expand coverage by The Health Plan.
- Receive medical advice or options communicated to you without any limitations or restrictions being placed upon the practitioner or PCP by The Health Plan.
- Be treated with respect, dignity, and privacy by The Health Plan employees, practitioners, and their staff. If you feel that your treatment has not been respectful, please call The Health Plan Customer Service Department at 1.888.613.8385.
- Get prompt resolution of issues raised, including complaints or grievances and issues relating to authorization, coverage, or payment of service(s). There are informal and formal steps available to you to resolve all complaints/grievances without reprisal from The Health Plan.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other federal regulations on the use of restraints and seclusion.
- Change your PCP at any time by calling or writing The Health Plan. The new PCP has to be available.
- Choose a participating PCP and OB/GYN and, with proper referrals, see a participating specialist.
- Be able to refuse care from the designated practitioner and select a different affiliated practitioner.
- Know how to obtain out-of-area services.
- Help make decisions about your health care when possible and within The Health Plan guidelines as outlined in this agreement, including the right to refuse treatment.
- Make an advance directive.
- Tell us your comments, opinions or complaints about The Health Plan or your medical care.
- Have coverage denials involving medical necessity or experimental treatment reviewed, after exhaustion of The Health Plan's internal grievance procedure, by appropriate medical professionals who are knowledgeable about the recommended or requested health care service, as part of an external review.



- Know how you can get a list of The Health Plan's practitioner network, including the names and credentials of all participating practitioners. You should know how to choose practitioners within the Health Plan. If you have any questions regarding the qualifications of any plan physician, please contact The Health Plan's Customer Service Department at 1.888.613.8385.
- Know you are free to exercise your rights. Exercising these rights does not adversely affect our treatment of you.
- Know how to obtain access to a summary of the Health Plan's accreditation report.
- Health care professionals, acting within the lawful scope of practice, are not prohibited or restricted from advising or advocating on behalf of a member's health status; medical care or treatment options (including any alternative treatment that may be self-administered); any information the member needs for deciding among all relevant treatment options; or the risks, benefits, and consequences of treatment or no treatment.
- Know that you will not be discriminated against in the delivery of health care services consistent with the benefits covered in your policy, based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, being homeless, sexual orientation, genetic information, or source of payment.
- Know you have full disclosure from your health care practitioner of any information relating to your medical condition or treatment plan and the ability to examine and offer corrections to your own medical records.
- Access emergency health care services, consistent with your determination of the need for such services as a prudent layperson, and post-stabilization services. No referral is needed.
- Know you can file a grievance for an administrative or medical complaint. You will continue to get good care and be treated with respect, even if you file a complaint.
- Receive continuation of benefits while your appeal is pending; however, you may have to pay for the cost of continuation of benefits if the appeal is upheld.
- Be able to have a practitioner or medical professional review any coverage denials according to The Health Plan review procedures.
- Get a second opinion from a qualified health care professional within or outside the network, at no cost to you. This second opinion could be in addition to that of a specialist referred by the PCP.
- Have all coverage denials reviewed by appropriate medical professionals consistent with The Health Plan's review procedures.
- Be informed of plan policies and any charges for which you may be responsible.
- A woman has the right to direct access, annually, to her OB/GYN for the purpose of a well woman examination without a referral from her PCP, and no woman shall be required to obtain a referral from her PCP as a condition to coverage of prenatal or obstetrical care.
- A woman whose plan provides coverage for surgical services in an inpatient or outpatient setting has the right to reconstruction of the breast following mastectomy and reconstructive or cosmetic surgery required as a result of an injury caused by the act of a person convicted of a crime involving family violence.
- A woman whose plan provides coverage for laboratory or X-ray services has a right to the following when performed for cancer screening or diagnostic purposes: (1) a baseline mammogram for women age 35 to 39, inclusive; (2) a mammogram for women age 40 to 49, inclusive, at least every two years; (3) a mammogram every year for women age 50 and over; (4) a pap smear at least annually for women age 18 and over.
- A non-symptomatic person over 50 years of age and a symptomatic person under 50 years of age have the right to colorectal cancer examinations and laboratory tests for colorectal cancer.
- Be able to have rehabilitation services.



- Receive child immunization services, which shall not be subject to payment of any deductible, per-visit charge and/or copayment.

A member with diabetes whose health benefits policy includes eye care benefits has the right to direct access to an optometrist or ophthalmologist of their choice from the panel without referral from their PCP for an annual diabetic retinal examination. When the diabetic retinal examination reveals the beginning stages of an abnormal condition, access to future examinations shall be subject to prior authorization from a PCP.

Statement of Members' Responsibilities

For The Health Plan to provide appropriate and medically necessary health care services and to allow you to get the most from your plan membership, we want to work together with you and your family. Please share in responsibilities by doing the following:

- Pick a PCP. You should keep a relationship with a PCP. The PCP will be the manager and medical home for your health care needs.
- Identify yourself as a THP member to avoid mistakes when you go to the practitioner or see another practitioner.
- **Always** carry The Health Plan ID. **Never** let anyone else use them.
- Read this handbook. You should follow the guidelines and contact The Health Plan for help, if needed.
- Let The Health Plan know any changes in the following:
 - Name, address, telephone number.
 - Number of dependents (marriage, divorce, new baby, child leaves home, etc.).
 - Loss of ID card.
 - Change of PCP.
- Be on time for appointments. If you cannot keep an appointment, call and cancel.
- Give details about your health to the physicians. This information is needed for the diagnosis and treatment of medical problems.
- Follow directions given by your practitioners, such as what medicines to take or what foods you should eat.
- If you get emergency care outside The Health Plan service area, call The Health Plan within 48 hours.
- You must talk with your PCP or OB/GYN **before** receiving specialty care or services.
- You must give The Health Plan information on other insurance you have or if you have worker's compensation or if you're in an accident. You may have to pay The Health Plan money owed under Coordination of Benefits or Subrogation policies.
- Please be friendly to The Health Plan's employees, practitioners and their staff.



Mountain Health Trust Members' Rights

As a member of The Health Plan, you have rights around your health care and to receive information according to contract standards. Each year, The Health Plan submits its annual report to the Bureau for Medical Services (BMS) and WVCHIP by April 1. This report includes a description of the services, personnel and the financial standing of THP.

The annual report is available to members by request only. To get a copy of the report, you can call Member Services at 1.888.613.8385. You can also get a copy of the report from BMS/WVCHIP.

You have the right to:

- Ask for and obtain all included information
- Be told about your rights and responsibilities
- Get information about The Health Plan, our services, our providers, and your rights
- Be treated with respect and dignity
- Not be discriminated against by The Health Plan
- Access all services that The Health Plan must provide
- Choose a provider in our network
- Take part in decisions about your health care
- Refuse treatment and choose a different provider
- Get information on treatment options and different courses of care according to the member's ability to understand
- Have your privacy respected
- Ask for and to get your medical records within 30 days of request
- Ask that your medical records be changed or corrected if needed within 60 days of request
- Be sure your medical records will be kept private
- Recommend changes in policies and procedures
- Be free from any form of restraint or seclusion used as a means of force, discipline, convenience, or retaliation
- Get covered services, no matter what cultural or ethnic background or how well you understand English
- Get covered services regardless of if you have a physical or mental disability, or if you are homeless
- Refer yourself to in-network and out-of-network family planning providers
- Access certified nurse midwife services and certified pediatric or family nurse practitioner services
- Get emergency post-stabilization services
- Get emergency health care services at any hospital or other setting
- Accept or refuse medical or surgical treatment under State law and to make an advance directive
- Have your parent or a representative make treatment decisions when you can't
- Make complaints and appeals
- Get a quick response to problems raised around complaints, grievances, appeals, authorization, coverage, and payment of services
- Ask for a state fair hearing after a decision has been made about your appeal
- Request and get a copy of this member handbook annually after initial enrollment
- Dis-enroll from your health plan
- To exercise your rights. Exercising these rights does not adversely affect our treatment of you.



- Ask us about our Quality Improvement program and tell us how you would like to see changes made.
- Ask us about our utilization review process and give us ideas on how to change it.
- Know the date you joined our health plan
- Know that we only cover health care services that are part of your plan
- Know that we can make changes to your health plan benefits as long as we tell you about those changes in writing
- Get news on how providers are paid
- Find out how we decide if new technology or treatment should be part of a benefit
- Ask for oral interpreter and translation services at no cost to you
- Use interpreters who are not your family members or friends
- Know you will not be held liable if your health plan becomes bankrupt (insolvent)
- Know your provider can challenge the denial of service with your permission

Your Responsibilities

As a member of The Health Plan, you also have some responsibilities:

- Read through and follow the instructions in your member handbook
- Work with your PCP to manage and improve your health
- Ask your PCP any questions you may have
- Call your PCP at any time when you need health care
- Give information about your health to The Health Plan and your PCP
- Always remember to carry your member ID card
- Only use the emergency room for real emergencies
- Keep your appointments
- If you must cancel an appointment, call your PCP as soon as you can to let him or her know
- Follow your PCPs recommendations about appointments and medicine
- Go back to your PCP or ask for a second opinion if you do not get better
- Call Member Services at 1.888.613.8385 whenever anything is unclear to you, or you have questions
- Treat health care staff and others with respect
- Tell us right away if you get a bill that you should not have gotten or if you have a complaint.
- Tell us and your DHHR caseworker right away if you have had a transplant or if you are told you need a transplant.
- Tell us and DHHR when you change your address, family status or other health care coverage.
- Know that we do not take the place of workers' compensation insurance



Provider Reporting Requirements

Reporting of Required Reportable Diseases

Health care providers are required to report certain diseases by state law. This is to allow for both disease surveillance and appropriate case investigation/public follow-up. THP may be responsible for (1) further screening, diagnosis and treatment of identified cases enrolled in THP as necessary to protect the public's health, or (2) screening, diagnosis and treatment of case contacts who are enrolled with THP. Detailed infectious disease reporting requirements can be obtained from the Bureau for Public Health within the Department of Health and Human Resources.

The three primary types of diseases that must be reported are:

1. Division of Surveillance and Disease Control, Sexually Transmitted Disease Program. According to WV Statute Chapter 16-4-6 and Legislative Rules Title 64, Series 7, sexually transmitted diseases (STDs) are required to be reported for disease surveillance purposes and for appropriate case investigation and follow-up. For contact notification, THP must refer case information to the Division of Surveillance and Disease Control. The Division has an established program for notifying partners of persons with infectious conditions. This includes follow-up of contacts to individuals with HIV and AIDS. Once notified, contacts who are members with THP may be referred for appropriate screening and treatment, if necessary.
2. Division of Surveillance and Disease Control, Tuberculosis Program. As per WV Statute Chapter 26-5A-4 and WV Regulations 16-25-3, individuals with diseases caused by *M. tuberculosis* must be reported to the WV Bureau for Public Health, DSDC, TB Program for appropriate identification, screening, treatment and treatment monitoring of their contacts.
3. Division of Surveillance and Disease Control, Communicable Disease Program. As per WV Legislative Rules Title 6-4, Series 7, cases of communicable disease noted as reportable in West Virginia must be reported to the local health departments in the appropriate time frame and method outlined in legislative rules. This both provides for disease surveillance and allows appropriate public health action to be undertaken—patient education and instruction to prevent further spread, contact identification and treatment, environmental investigation, outbreak identification and investigation, etc. (Note: Per legislative rule, reports of category IV diseases [including HIV and AIDS] are submitted directly to the state health department, not to local jurisdictions.)

Federal Reporting Requirements

The Health Plan must comply with the following Federal reporting and compliance requirements for the services listed below and must submit applicable reports to BMS/WVCHIP. (See Medicaid Physician Provider Manual for state requirements and procedures):

- Abortions must comply with the requirements of 42 CFR 441. Subpart E – Abortions. This includes completion of the information form, Certification Regarding Abortion.
- Hysterectomies and sterilizations must comply with 42 CFR 441. Subpart F –Sterilizations. This includes completion of the consent form. Under WV 2020 Senate Bill 716 tubal ligation (or sterilization) may be provided without waiting 30 days after informed consent.
- EPSDT services and reporting must comply with 42 CFR 441 Subpart B – Early and Periodic Screening, Diagnosis, and Treatment.



Provider Responsibilities and Reimbursement

Providers must inform members of the costs for non-covered services prior to rendering such services. Providers are prohibited from collecting copays for missed appointments. Please remember that members are held harmless for the costs of all MHT-covered services provided, except for any cost-sharing obligations.

You are required to treat all information that is obtained through the performance of the services in your contract as confidential information to the extent that confidential treatment is provided under state and federal laws, rules, and regulations.

If you have any questions regarding an MHT member's eligibility, please call our Customer Service at 1.888.613.8385, Monday – Friday, 8:00 a.m. to 5:00 p.m. Please remember that WV Medicaid and WVCHIP determines eligibility for a member to be in managed care.

The Health Plan encourages provider training to promote sensitivity to the special needs of this population.

The Health Plan does not discriminate against providers acting within the scope of their license. Health care professionals, acting within the lawful scope of practice, are not prohibited or restricted from advising or advocating on behalf of a member's health status; medical care or treatment options (including any alternative treatment that may be self-administered); any information the member needs for deciding among all relevant treatment options; or the risks, benefits, and consequences of treatment or no treatment.

The Health Plan may not make specific payments, directly or indirectly, to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to any particular member. Indirect payments may include offerings of monetary value (such as stock options or waivers of debt) measured in the present or future.

We will provide information to members regarding their rights and responsibilities and any changes upon enrollment, annually, and at least 30 days prior to any change in their benefits.

Provider Overpayments

The Health Plan is responsible for the recovery of all overpayments, including those due to fraud, waste, and abuse. In addition to internal processes to identify any overpayments, THP has a process in place for network providers to report receipt of an overpayment. The provider is required to notify THP in writing of the reason for the overpayment and return the full amount of the overpayment to THP within 60 calendar days after the date on which the overpayment was identified. In the event that THP makes an overpayment to a provider, THP must recover the full amount of the overpayment from the provider. This recovery will be administered through the claims system by offsetting the overpayment against future claims payments.

BMS/WVCHIP also reserves the right to collect overpayments in some instances. The provider will be notified by BMS/WVCHIP if this is to occur. The provider's appeal rights in the event of BMS collecting an overpayment directly from the provider are outlined in the BMS Policy Manual, chapter 800(B).



Provider Reimbursement

If a provider's reimbursement is tied to a WV MHT fee schedule, THP is required to implement any rate changes adopted by BMS/WVCHIP within 30 calendar days of notification of the rate change. THP must pay the new rate for claims not yet paid with a date of service on or after the effective date of change. The Health Plan must reprocess any claims paid between the notification date and the system load date to the updated rate. This provision does not apply to payments made to CAH or payments made to FQHCs/RHCs.

Changes to Provider Fee Schedules

If a provider is reimbursed based upon the WV Medicaid or WVCHIP fee schedule the following processes will be followed when updated rates are received from BMS/WVCHIP, per THP's managed care contract with the State.

FQHC/RHC

Upon BMS/WVCHIP notification to The Health Plan of any changes to the FQHC/RHC reimbursement rates, The Health Plan must update payment rates to FQHC/RHCs to the effective date in the notification by BMS/WVCHIP. The Health Plan must pay the new rate for any claims not yet paid with a date of service on or after the effective date of change. If payment has already been made for a claim within the current state fiscal year with a date of service on or after the effective date of the rate change, The Health Plan must reprocess the claim to reimburse at the new rate. The new payment rate must be loaded into The Health Plan's claims payment system within thirty (30) calendar days of notification of the payment rate change.

THP must offer FQHCs and RHCs terms and conditions, including reimbursement, which are at least equal to those offered to other providers of comparable services.

Critical Access Hospitals

Upon BMS/WVCHIP notification to The Health Plan of any changes to the CAH reimbursement rates, The Health Plan must update payment rates to CAH effective from the designated CMS effective date. The Health Plan must pay the new rate for claims not yet paid with a date of service on or after the effective date of change. The new payment rate must be loaded into The Health Plan's claims payment system within thirty (30) days of notification of the payment rate change.

Other Fee Schedules

(RBRVS, CLFS, Imaging, etc.)

In the case of provider reimbursement that is tied to the Medicaid fee-for-service rate schedule or WVCHIP fee schedule, The Health Plan is required to implement any rate changes adopted by the Department within thirty (30) calendar days of notification of the rate change. The Health Plan must pay the new rate for claims not yet paid with a date of service on or after the effective date of change. The Health Plan must reprocess any claims paid between the notification date and the system load date to the updated rate.



Alternative Payment Models

The Health Plan deploys several APMs for various provider types throughout our service area, including bonus payments, care coordination payments with shared savings for meeting quality measures, and total cost of care models. By analyzing multiple years of financial data, as well as three years of clinical-based analytic data, THP creates APMs that meet the “quadruple aim of health care”—that is, improving the quality of care, achieving lower costs, promoting better health outcomes, and reducing provider burnout.

THP adheres to a risk readiness approach to APMs developed by the Health Care Payment Learning and Action Network. THP seeks to meet providers and practitioners where they are on this risk continuum. To date, THP's APMs are either category 2A through C or 3A. These APMs include payment bonuses or upside risk only. No payments are taken back or withheld from the provider(s). THP may offer shared risk APMs in the future.

THP collaborates with providers to develop APMs that are the best fit for their needs, as well as the needs of our members. THP does not have panel size requirements or other restrictions on its APMs. If your organization wishes to discuss APMs, please call 1.304.285.6508.



Marketing Guidelines

The Health Plan may conduct general advertising that does not specifically solicit the MHT population. The Health Plan must submit to BMS/WVCHIP for prior written approval a marketing plan and all marketing materials prepared pursuant to said plan and the MHT contract.

Prohibited Marketing Practices

The following prohibitions are applicable to The Health Plan, its agents, subcontractors, and The Health Plan providers:

1. Distributing marketing materials without prior BMS/WVCHIP approval
2. Using the word, "Mountain," or phrase, "Mountain Health," "Health Bridge", except when referring to Mountain Health Trust, West Virginia Health Bridge or other State programs
3. Distributing marketing materials written above the sixth grade reading level, unless approved by BMS/WVCHIP
4. Offering gifts valued over \$15 to potential members
5. Providing gifts to providers for the purpose of distributing them directly to The Health Plan's potential members or currently enrolled members
6. Directly or indirectly, engaging in door-to-door, email, text, telephone, and other cold call marketing activities
7. Marketing in or around public assistance offices, including eligibility offices
8. Using spam (an unwanted, disruptive commercial message posted on a computer network or sent by email)
9. Knowingly marketing to persons currently enrolled in another MCO directly by mail, phone or electronic means of communication
10. Inducing or accepting a member's enrollment or disenrollment
11. Using terms that would influence, mislead, or cause potential members to contact The Health Plan, rather than the enrollment broker, for enrollment
12. Portraying competitors in a negative manner
13. Using absolute superlatives (e.g., "the best," "highest ranked," "rated number 1") unless they are substantiated with supporting data provided to BMS/WVCHIP
14. Making any written or oral statements containing material misrepresentations of fact or law relating to The Health Plan or the Medicaid program, services, or benefits
15. Making potential member gifts conditional based on enrollment with The Health Plan
16. Charging members for goods or services distributed at The Health Plan or Medicaid events
17. Charging members a fee for accessing The Health Plan's website
18. Influencing enrollment in conjunction with the sale or offering of any private insurance
19. Tying enrollment in The Health Plan with purchasing (or the provision of) other types of private insurance;



20. Using marketing agents who are paid solely by commission
21. Posting The Health Plan-specific, non-health related materials or banners in provider offices
22. Conducting potential member orientation in common areas of providers' offices
23. Allowing providers to solicit enrollment or disenrollment in The Health Plan, or distribute The Health Plan-specific materials at a marketing activity (This does not apply to health fairs where providers do immunizations, blood pressure checks, etc. as long as the provider is not soliciting enrollment or distributing plan specific The Health Plan materials.)
24. Purchasing or otherwise acquiring mailing lists from third-party vendors, or for paying BMS/WVCHIP contractors or subcontractors to send plan specific materials to potential members
25. Referencing the commercial component of The Health Plan in any marketing materials
26. Discriminating against a member or potential member because of race, age, color, religion, natural origin, ancestry, marital status, sexual orientation, physical or mental disability, health status or existing need for medical care, with the following exception: certain gifts and services may be made available to members with certain diagnoses
27. Assisting with The Health Plan enrollment form
28. Making false, misleading or inaccurate statements relating to services or benefits of The Health Plan or Medicaid program, or relating to the providers or potential providers contracting with The Health Plan
29. Direct mail marketing to potential members.

MCO Social Media Marketing Practices

In addition to all marketing requirements outlined in this Contract, The Health Plan must comply with the social media marketing practices as outlined below.

Social Media Marketing Guidelines

The following list is applicable to The Health Plan, its agents, subcontractors, and providers:

1. At BMS/WVCHIP approval, The Health Plan may engage in forms of social media advertising (i.e. Twitter, Facebook, Instagram)
2. At BMS/WVCHIP approval, The Health Plan may purchase advertisement banners on social media outlets. The content of such advertisements must be approved by BMS prior to distribution
3. The Health Plan may post Medicaid/WVCHIP events on social media sources. The content of such posts must be approved by BMS/WVCHIP approval prior to posting
4. The Health Plan may post general non-advertising information regarding The Health Plan activities. The content of such posts does not require BMS/WVCHIP prior approval, and
5. Any member complaints received through the social media sources must be processed and resolved through the general complaint intake system.



Social Media Prohibitions

The following prohibitions are applicable to The Health Plan, its agents, subcontractors, and providers:

1. Posting or sending personal or protected private health information on social media
2. Advertising on social media platforms that entail direct communication with potential members. This list includes, but is not limited to: Snapchat, Skype, WhatsApp, Facebook Messenger, MeetUp, Viber, and any other personal communication services
3. Responding to any comments on social media posts from potential members except when to provide a general response, such as giving a phone number or link to a website or the enrollment broker phone number
4. Partaking in individual communication on social media outlets
5. Requesting followers or adding individuals as friends or tagging individuals on social media sources (i.e., Facebook, Instagram, Twitter).

Reporting and Investigating MCO Marketing Violations

The Health Plan must establish a process to ensure fair and consistent investigation of alleged violations of BMS/WVCHIP marketing policies.

Upon written receipt of any alleged MCO violation(s) from BMS/WVCHIP, The Health Plan must:

1. Acknowledge receipt, in writing, within one (1) business day from the date of the receipt of the alleged violation.
2. Begin investigation of the alleged violation and complete investigation within fourteen (14) calendar days from the date of the receipt of the alleged violation.
3. Analyze the findings of the investigation and report findings to BMS/WVCHIP.



West Virginia MHT Provider Required Provisions

The Health Plan is contracted with West Virginia Bureau for Medical Services (BMS) and West Virginia Children's Health Insurance Program (CHIP). The West Virginia Mountain Health Trust Program requires specific contractual provisions for all contracted providers that participate with the West Virginia Mountain Health Trust program or choose to provide services to West Virginia Medicaid and WVCHIP recipients on an intermittent basis. In addition to the terms contained within the Agreement, the following provisions are applicable specifically to Facility, Physician, Practitioner, and Ancillary Medical Care Providers that provide services to West Virginia MHT recipients.

A. Obligations of Emergency Care Providers

- Emergency Care Providers must provide education to MHT members regarding the cost of their copay for non-emergency services received in the Emergency Department, including alternate locations where non-emergency can be obtained.

B. Obligations of Providers with Respect to Member Copays

- Enrollees will be held harmless for the costs of all MHT-covered services provided except for applicable cost-sharing obligations. Providers must inform members of the costs or non-covered services prior to rendering such services.
- Providers agree that The Health Plan's members may not be held liable for The Health Plan's debts in the event of The Health Plan's insolvency.
- In accordance with the regulatory requirements promulgated by BMS, providers may not routinely waive required copays.
- Providers may not charge a copay for the following services:
 - Family Planning Services
 - Emergency Services
 - Behavioral Health Services
 - Members under age 21
 - Pregnant women (including postpartum visit)
 - American Indians and Alaska Natives
 - Members receiving hospice care
 - Members in nursing homes
 - Other services excluded under State Plan Authority
 - Members who have met their maximum cost sharing obligation per quarter; or
 - Missed appointments.
- Providers must charge a copay for the following:
 - Inpatient and Outpatient Services
 - Physician office visits
 - Non-emergency use of an Emergency Department
 - Caretaker relatives age 21 and above
 - Transitional Medicaid members age 21 and above; and
 - Other members identified by The Health Plan not specifically exempt.



C. Other Obligations of Provider

- Physician may not refuse to furnish covered services to the eligible member on account of a third party's potential liability for the service(s).
- Physician agrees to comply with The Health Plan's Quality Assurance/Performance Improvement (QAPI) Program requirements.
- Providers that order, refer, or render covered services must enroll with BMS/WVCHIP, through the fiscal agent, as a Medicaid/CHIP provider, as required by 42 CFR 438.602(b). Enrollment with BMS does not obligate provider to offer services under the BMS fee-for-service delivery system. The Health Plan is not required to contract with a provider enrolled with the West Virginia Bureau for Medical Services/CHIP that does not meet The Health Plan's credentialing or other requirements.
- Provider must attest to the following certification for claims for MHT goods and services:
 - All statements are true, accurate, and complete
 - No material fact has been omitted
 - All services will be medically necessary to the health of the specific patient; and
 - The provider understands that payment will be from Federal and State funds and that any falsification or concealment of a material fact may be prosecuted under Federal and State law.
- Providers shall maintain malpractice insurance with minimum coverage requirements of \$1 million per episode and \$1 million in aggregate.
- Provider shall supply a certification that neither provider nor provider's director(s), officer(s), principal(s), partner(s), managing employee(s), or other person(s) with ownership or control interest of five percent (5%) or more in provider have not been excluded, suspended, debarred, revoked, or any other synonymous action from participation in any program under Title XVIII (Medicare), Title XIX (Medicaid), or under the provisions of Executive Order 12549, relating to federal agreement. This certification shall state that all persons listed above have also not been excluded, suspended, debarred, revoked, or any other synonymous action from participation in any other state or federal health-care program. Provider shall notify The Health Plan immediately at the time it receives notice that any action is being taken against a physician or any other person above, as defined under the provisions of Section 1128(A) or (B) of the Social Security Act (42 USC § 1320a-7), which could result in exclusion from the Medicaid program. Provider agrees to fully comply at all times with the requirements of 45 CFR Part 76, relating to eligibility for federal agreements and grants.
- Primary Care Physicians must comply with timeliness of access standards as defined by BMS/WVCHIP.



D. The Health Plan's Reimbursement Responsibilities

- The Health Plan is solely responsible for payment of covered and authorized services to West Virginia MHT recipients as long as the member is eligible for services on the date of service. Provider shall not seek reimbursement directly from West Virginia Bureau for Medical Services.
- The reimbursement terms for West Virginia MHT recipients are set forth in the Provider's Master Agreement.
- The Health Plan will not make specific payment, directly or indirectly, to provider as an inducement to reduce or limit medically necessary services furnished to any particular member.

E. Reporting Actions against Physician, Owners, or Others

- Provider must notify The Health Plan immediately after it receives notice that any action is being taken against provider or any physician, owners, persons with control interest, managing employees, partners, directors, and officers, as defined under the provisions of Section 1128(A) or (B) of the Social Security Act (42 USC § 1320a-7), which could result in exclusion from the Medicaid program. The provider must agree to fully comply at all times with the requirements of 45 CFR Part 76, relating to eligibility for federal agreements and grants.

F. Compliance with Health Insurance Portability and Accountability Act

- Provider shall comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law 104-191), and the Health Information Technology for Economic and Clinical Health Act (HITECH Act) at 42 U.S.C. 17931, et. seq. Provider must treat all information that is obtained through the performance of the services contemplated by the agreement, including this amendment, as confidential information to the extent that confidential treatment is provided under state and federal laws, rules, and regulations. This expectation of confidentiality shall include, but is not limited to, information relating to applicants or members of BMS/WVCHIP programs.

G. Compliance with Deficit Reduction Act Requirements

- Provider must comply with the Section 6032 of the Deficit Reduction Act of 2005 and the SMDL 06-024. If provider receives annual Medicaid payments of at least \$5 million (cumulative, from all sources), the provider must:
 - Establish written policies for all employees, managers, officers, contractors, subcontractors, and agents of physician. The policies must provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in Section 1902(a)(68)(A).
 - Include as part of such written policies detailed provisions regarding the provider's policies and procedures for detecting and preventing Fraud, Waste, and Abuse.
 - Include in any employee handbook a specific discussion of the laws described in Section 1902(a)(68)(A), the rights of employees to be protected as whistleblowers, and the provider's policies and procedures for detecting and preventing Fraud, Waste, and Abuse.



H. Required Disclosures by Provider

- Provider shall provide The Health Plan and BMS/WVCHIP with all information requested of provider, including required disclosures regarding ownership and control, in accordance with 42 CFR § 455.104. In addition to any other information requested by The Health Plan or BMS/WVCHIP, provider shall disclose the name and address of any person (individual or corporation) with an ownership or control interest in provider. In the case of individuals, such required information shall include date of birth and Social Security number for each individual having an ownership or controlling interest in Provider. Consistent with 42 CFR § 455.101, The Health Plan defines “ownership interest” and “ownership” as follows:
 - Ownership interest means the possession of equity in the capital, the stock, or the profits of provider.
 - Person with an ownership or control interest means a person or corporation that:
 - Has an ownership interest totaling 5 percent or more in a disclosing entity;
 - Has an indirect ownership interest equal to 5 percent or more in provider;
 - Has a combination of direct and indirect ownership interests equal to 5 percent or more in provider;
 - Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
 - Is an officer or director of a provider practice that is organized as a corporation; or
 - Is a partner in a provider practice that is organized as a partnership.
- In addition to the required ownership and control disclosures required by 42 CFR 455.101, provider shall disclose the name of any other Medicaid-recipient organizations in which any of its owners have an ownership or controlling interest, as required by 42 CFR 455.104(b)(3).
- A provider that is a business entity, corporation, or a partnership must disclose the name, date of birth, Social Security number, and address of each person who is provider's director, officer, principal, partner, agent, managing employee, or other person with ownership or control interest of five percent (5%) or more in the provider or in the provider's subcontractor.

The address for corporate entities must include, as applicable, primary business address, every business location, P.O. Box address, and tax identification number.
- Provider must provide information on the interrelationships of persons disclosed per 42 CFR § 455.104(b). This required information includes whether the person (individual or corporation) with an ownership or control interest in provider is related to another person with ownership or control interest in provider as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which provider has a 5 percent or more interest is related to another person with ownership or control interest in provider as a spouse, parent, child, or sibling.
- Provider agrees to keep its disclosed information regarding ownership and control current at all times by informing The Health Plan, in writing, within thirty-five (35) calendar days of any ownership or control changes.
- Provider must disclose any significant business transactions, in accordance with 42 CFR § 455.105. Provider is required to disclose full and complete information about the following



information related to business transactions within thirty-five (35) calendar days of request of the Secretary of DHHS or BMS/WVCHIP:

- The ownership of any subcontractor with whom provider has had business transactions totaling more than \$25,000 during the previous 12-month period; and
- Any significant business transactions between provider and any wholly owned supplier, or between provider and any subcontractor, during the previous five (5) years.
- Provider must disclose any healthcare-related criminal convictions, in accordance with 42 CFR § 455.106, of any physician or provider's director, officer, principal, partner, agent, managing employee, or other person with ownership or control interest of five percent (5%) or more in provider, relating to Medicare, Medicaid, or Title XX programs. These disclosures are required at the time that provider applies or renews its applications for Medicaid participation or at any time on request. Provider must notify The Health Plan immediately at the time provider receives notice of any such conviction. For purposes of this amendment and the underlying agreement, and consistent with 42 CFR § 1001.2, "Convicted" shall mean:
A judgment of conviction has been entered against an individual or entity by a Federal, State or local court, regardless of whether:
 - There is a post-trial motion or an appeal pending, or
 - The judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed;
 - A Federal, State or local court has made a finding of guilt against an individual or entity;
 - A Federal, State or local court has accepted a plea of guilty or *nolo contendere* by an individual or entity; or
 - An individual or entity has entered into participation in a first offender, deferred adjudication or other program or arrangement where judgment of conviction has been withheld.
- Provider shall report to The Health Plan all provider-preventable conditions associated with claims.

I. **Maintenance and Access of Records**

- If provider places required records in another legal entity's records, such as a hospital, the provider shall be responsible for obtaining a copy of these records for use by the government entities or their representative.
- Provider must provide to BMS/WVCHIP:
 - All information required under The Health Plan's managed care contract with BMS/WVCHIP, including but not limited to the reporting requirements and other information related to a provider's performance of its obligations under its provider contract with The Health Plan; and
 - Any information in provider's possession sufficient to permit BMS/WVCHIP to comply with the federal Balanced Budget Act of 1997 or other federal or state laws, rules, and regulations. If provider places required records in another legal entity's records, such as a hospital, provider is responsible for obtaining a copy of these records for use by the above-named entities or their representative.



J. Use of Information Obtained Through Agreement

- The provider shall not use information obtained through the performance of The Health Plan agreement, or this amendment, in any manner except as is necessary for the proper discharge of obligations and securing of rights under the agreement.

K. Prohibition against Direct Marketing

- Provider is prohibited from engaging in direct marketing to members that is designed to increase enrollment in The Health Plan. This prohibition does not constrain Provider from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance.

L. Non-Interference with Rights of The Health Plan and the State

- Provider shall take no actions that interfere with or place any liens upon the State's right or The Health Plan's right, acting as the State's agent, to recovery from third-party resources.

M. Compliance with Advance Directives Requirements

- Provider shall comply with 42 CFR § 422.128 and West Virginia Health Care Decisions Act relating to advance directives.

N. Right to Recover Overpayments from Provider

- Provider shall notify The Health Plan, in writing, of any overpayment discovered by Provider. This required notification shall include the reason for any overpayment. Provider shall return the full amount of the overpayment to The Health Plan within sixty (60) calendar days after the date on which the overpayment was identified.
- BMS/WVCHIP has the right to recover provider overpayments, including those overpayments due to Fraud, Waste, and Abuse, from provider if:
 - BMS/WVCHIP or its contractor identifies an overpayment made by The Health Plan to provider
 - The payment occurred outside the grace period, as defined by BMS/WVCHIP
 - The Health Plan has not previously identified the overpayment via the deconfliction process outlined herein
 - The Medicaid Fraud Control Unit (MFCU) or other law enforcement entity is not pursuing provider, and
 - BMS/WVCHIP, in its sole discretion, determines it is unable to collect from The Health Plan.
- THP may seek recoupment of payments for up to twenty-four (24) months from the date of service of the claim, per its agreement with BMS. For fraud, waste or abuse claims, there is no time limit on recoveries.
- In the event the State collects overpayments directly from provider, provider's appeal rights are outlined in the BMS policy manual Chapter 800(B), which can be found on the BMS website.



Medicaid Drug Testing Policy

Effective July 1, 2018, based on The American Society of Addiction Medicine (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. Full ASAM guidelines can be found on the [ASAM website](#).

The Health Plan follows the benefit limits established by BMS

- Code limit for presumptive drug screens (80305, 80306, and 80307) is now 24 in combination per calendar year. Medical necessity authorization is required beyond service limits.
- 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.
- G0483- definitive drug testing for 22 or more drug classes requires medical necessity prior authorization from the INITIAL service prior to service being rendered unless it is the result of an emergency room visit.
- G0659- definitive drug testing to identify drugs that do not have a specific test available requires medical necessity prior authorization from the INITIAL service prior to services being rendered.
- To exceed the benefit limit, providers must contact The Health Plan to obtain a medical necessity authorization.

The complete policy can be located on the [BMS website](#).

Breathalyzer Testing

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 made 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 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 of medical necessity.



Medicaid Transplant

Members receiving transplant services are exempt from managed care.

Non-Par Provider

Non-participating providers must obtain prior authorization for claims to be reimbursed.

Prior Authorization

Effective January 1, 2017, all providers are required to request prior authorization before a service is rendered. This requirement includes both outpatient and inpatient services. If service is rendered after hours, over the weekend or on a holiday, providers are required to request authorization the next business day. Prior authorization requests received after the next business day will not be processed. Failure to follow prior authorization guidelines will result in denied claims.

Medicaid Chiropractic Service

Manipulation and X-ray procedure codes along with 99201, 99202, and 99203 will be covered per contract. Effective April 1, 2020 physical therapy codes have been added as a covered service. Benefit limits are still in effect.

Physical and Occupational Therapy

Therapy codes are not payable without one of these modifiers to distinguish the discipline of the plan of care under which the service is delivered.

- **GO**: Indicates services delivered under an outpatient **occupational** therapy plan of care
- **GP**: Indicates services delivered under an outpatient **physical** therapy plan of care

Inpatient Claims

In order to be consistent with the payment policies currently utilized by CMS for Medicare, Medicaid's fiscal agent for WV Medicaid, and general industry standards for commercial payors, THP changed our claims processing policy regarding hospital and skilled nursing inpatient admissions. **Effective July 1, 2017**, THP began processing payments for inpatient admissions based on the discharge date of the inpatient stay. This affects any claim for an inpatient admission where the reimbursement terms of our contract are based upon a DRG, case rate, per diem or percent of billed charges methodology.



Medicaid NDC Rebate Eligible Drugs

The Health Plan cannot reimburse for drugs, drug products, and related services, which are defined as a non-covered benefit by the department's outpatient drug pharmacy program.

In accordance with 42 U.S.C. § 1396r-8, THP must exclude coverage for any drug marketed by a drug company (or labeler) that does not participate in the federal drug rebate program. THP is not permitted to provide coverage for any drug product, brand name or generic, legend or non-legend, sold or distributed by a company that did not sign an agreement with the federal government to provide Medicaid rebates for that product.

The Medicaid drug rebate program was created by the Omnibus Budget Reconciliation Act of 1990 (OBRA '90) which added Section 1927 to the Social Security Act and became effective on January 1, 1991. The law requires that drug manufacturers enter into an agreement with the Centers for Medicare and Medicaid Services (CMS) to provide rebates for their drug products that are paid by Medicaid. Manufacturers that do not sign an agreement with CMS are not eligible for federal Medicaid coverage of their products. Since 1991, it has been required that outpatient Medicaid pharmacy providers dispense only rebateable drugs and bill with the NDCs. Now, with the Deficit Reduction Act of 2005, this requirement is being expanded to include physician-administered drugs.

Drugs administered by the physician and billed with an NDC must be rebateable in order to be eligible for payment, otherwise the drug will be denied. Providers can refer to the [CMS website](#) to determine if an NDC is manufactured by a company that participates in the federal drug rebate program or consult your wholesaler for assistance. **Failure to submit all required information such as NDC code, unit of measurement and quantity will result in a complete claim denial** (see provider billing instructions for requirements).

Unit of Measurement codes are:

- F2 -International Unit
- GR-Gram
- ML-Milliliter
- UN- Unit

340b providers are required to use modifier **UD** when submitting claims.

[FAQs](#) related to this requirement can be found on the Bureau for Medical Services website.



Readmissions Review Occurring Within 30 Days

Effective November 1, 2018, all clinically related/potentially preventable readmissions occurring within a thirty (30) day period are subject to review and denied in the event it is determined that the patient was prematurely discharged from the same hospital, the facility failed to have proper and adequate discharge planning in place, or if there was a lack of proper coordination between the inpatient and outpatient health care teams. In the absence of information to determine the appropriateness of the readmission from hospital review staff, submitted records or physician contact with the plan, clinically related/potentially preventable readmissions within a seven (7) day period will be automatically denied and the provider will need to provide medical documentation to support the need for payment. Final review decisions will be made/confirmed by an employed medical director of The Health Plan.

Wrong procedures or procedures performed on the wrong side, wrong body part, or wrong person, are commonly referred to as "never events." As a reminder, all never events are considered not medically necessary, and reimbursement is not allowed. Questions regarding claim denials may be directed to The Health Plan's provider number at 1.877.847.7901.

See **Section 7** of this Manual for information on THP's 30 Day Hospital Readmission Utilization Management Review Guideline. See **Section 12** of this Manual for billing guidelines related to readmissions occurring within 30 days of discharge from an inpatient facility.

Medicaid Substance Use Disorder (SUD) Goals

THP supports the following goals related to SUD:

1. Improve the quality of care and population health outcomes for Medicaid members with SUD
2. Increase member access to, and utilization of, appropriate SUD treatment services based on the American Society of Addiction Medicine (ASAM®) Criteria
3. Decrease medically inappropriate and avoidable utilization of high-cost emergency department and hospital services by members with SUD
4. Improve care coordination and care transitions for Medicaid members with SUD; and
5. Follow the CMS standards and guidelines as stated in the Special Terms and Conditions of the West Virginia approved 1115 SUD Waiver.

SUD Provider Training and Education Requirements

SUD providers are responsible for providing training and education to their staff on the ASAM® Level of Care criteria and the application of the ASAM® criteria in the assessment process. During provider enrollment, The Health Plan will obtain attestation from the SUD provider that ASAM® criteria will be applied appropriately by the provider's SUD program staff. As part of BMS' quality monitoring strategy, personnel and clinical records of a sample of the provider network will be reviewed to evaluate if there is appropriate application of and fidelity to the ASAM® Levels of Care and the Medicaid Provider Manual. BMS' ASO contractor will perform these retro reviews of providers to ensure SUD program providers are consistently applying ASAM® criteria throughout an individual's stay and that documentation and personnel records meet established Medicaid standards.



Peer Recovery Support Services

A Peer Recovery Support Specialist must be certified as outlined in the West Virginia Medicaid Provider Manual, Chapter 504. BMS-approved training program provides Peer Recovery Support Specialists with a basic set of competencies necessary to perform the peer support function. The Peer Recovery Support Specialist must demonstrate the ability to support the recovery of others from SUD. Similar to other provider types, ongoing continuing educational requirements for Peer Recovery Support Specialists must be in place.

Prior authorization protocols and complete billing guidelines for Peer Recovery Support Services (billing code H0038) for the West Virginia Medicaid line of business are available [here](#).

Medicaid ER All-Inclusive

THP is following the requirements outlined in the BMS hospital manual around the all-inclusive rate for emergency services.

Medicaid covers five levels of emergency room services. There are five CPT procedure codes available for billing emergency room services.

The enhanced reimbursement is an **all-inclusive fee**, which is considered to include the following items:

- Use of emergency room
- Routine supplies (such as sterile dressings)
- Minor supplies (bandages, slings, finger braces, etc.)
- Pharmacy charges
- Suture, catheter, and other trays
- IV fluids and supplies - routine EKG monitoring
- Oxygen administration and O₂ saturation monitoring

Diagnostic procedures including lab and radiology may be billed separately and in addition to the emergency room services

Outpatient Services for Acute and Critical Access Hospitals

Effective January 1, 2020, CPT/HCPCS codes are required to be submitted with the applicable revenue code for all outpatient services. Revenue codes that are submitted without the corresponding procedure code will be denied.

Surgical procedures must be billed with the appropriate CPT or HCPCS code and revenue code. Units are reported in fifteen (15) minute time increments. Charges and total time units for the procedure(s) must be rolled to the primary, most complex procedure and billed on one line. If you wish to report multiple procedures, bill all additional lines with zero units and zero charges.



Paper Claim Submissions

For 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](#). Contact your practice management consultant to learn how. You may access contact information for the practice management consultant assigned to your county by viewing the territory map located on our [website](#).

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.

Disclosure

THP follows the requirements related to Indians, Indian Health Care Providers, and Indian Managed Care Entities in accordance with the terms of 42 Code of Federal Regulations (CFR) 438.14.

THP permits any Indian who is enrolled in THP and eligible to receive services from a participating Indian Health Service, Tribes and Tribal Organizations, or Urban Indian Health Program (I/T/U) provider to choose to receive covered services from that I/T/U provider.

Value Added Services for Members

Members may qualify for incentives by completing health activities throughout the year. By helping members to accomplish these activities, you increase your practice's quality scores by providing them the services that they need. The healthy activities for 2021 are listed on the flyer on the next pages.



Mountain Health Trust

Value Added

Services

24-hour
nurse line:
1.800.624.6961

| Members | Value Add |
|--|---|
| Access to CoreWellness, an online tool to help members learn ways to get and stay healthy | |
| Health risk assessments | |
| Dedicated care managers to help members manage medications, disease and improve overall health | |
| Specialized care managers for neonatal abstinence syndrome (NAS), NICU, high-risk obstetrics, hepatitis, and behavioral health. Face-to-face case management with high-risk members with specialized care managers | |
| One-on-one education with asthma nurse educator | Asthma pack with peak flow meter, spacer and carrying pack available upon request |
| Diabetes Outreach Program | |
| • Completion of a HbA1c blood test | \$25 Gift Card |
| • Diabetic eye exam | \$25 Gift Card |
| • Diabetes education by case managers | |
| • One-on-one education by diabetes educators on glucometer, insulin pump use and general diabetes education | |
| Unlimited calls to Member Services and free wellness and appointment reminder texts | Cell phone with minutes for text & voice |
| Personal assistance with applying for SSI | |
| One-on-one help to quit smoking with a certified coordinator | |
| <u>Members 12 & older:</u> Quit smoking packets with workbook, relaxation exercises and quit smoking survival kit | |
| Referral to Jobs & Hope West Virginia program aiding members in recovery from substance use disorder | Job training and financial education classes |
| Teladoc | 24/7/365 Access to providers for non-emergent care |

1110 Main Street
Wheeling, WV 26003
healthplan.org



Already a member?

Call 1.888.613.8385 to learn more about getting these benefits.

Eligible for Medicaid/WVCHIP?

The Health Plan is the right plan for you! Call 1.800.449.8466 to learn more.

Pregnant, New Moms & Mothers

Maternity Outreach Program:

- Completion of 6 prenatal visits
- Post-partum visit

Value Add

\$100 Gift Card
\$50 Gift Card

Care coordination through baby's 1st year for mother's with high-risk pregnancies

Care coordination through baby's 1st year for mother's with substance use disorder during pregnancy

Text4Baby messages to keep mom and baby healthy

NICU babies or babies with complex conditions

Children

Value Add

Dental exam under 21 years of age

\$25 Gift Card

Yearly well visit 3 – 21 years of age

\$25 Gift Card

Boy Scouts 5 – 18 years of age

Annual Membership

Girl Scouts 5 – 18 years of age & members 18+ wishing to volunteer and mentor to join

Annual Membership

Boys & Girls Club 6 – 18 years of age

Annual Membership

Women

Value Add

Completion of Pap Smear

\$25 Gift Card

Completion of mammogram for women aged 40 and over

\$50 Gift Card

Help in your language

Do you need help communicating with us or reading what we send you? We provide our letters in other languages and large print at no cost to you. Call our toll-free Customer Service Department at 1.888.613.8385 (TTY: 711).

Plan On It.
healthplan.org

rvsd 1.14.21

Section 6

Office Copays,
Medical Copays,
Co-insurance &
Deductibles





Office Visit Copays, Medical Copays, Co-insurance & Deductibles

The Health Plan offers a variety of benefit plans that require the member to be responsible for a portion of the cost of services. Member responsibility may take the form of copays for office visits or other medical services, co-insurance amounts, and deductibles. As groups re-enroll annually, the member copayment may change, depending upon the plan selected by the employer.

Office visit copay/medical copay

Generally, copays are a fixed amount, but may be a percentage of the allowed amount that is associated with a specific service such as an office visit, therapy visit, or diagnostic service and would be the member's responsibility. Members are expected to pay this amount at the time of service.

It is imperative that provider offices ask for the member's ID card at every visit. A sample of The Health Plan ID cards are shown on the product matrix located in [Section 3](#).

Copays may not be waived, as this is in direct violation of the provider's contract.

The copay should be collected at the time of service, unless other arrangements have been made.

Copays DO NOT apply to hospital inpatient physician visits, preventive services and/or prenatal office visits (after the initial visit), physician nursing home visits, or patient home visits when determined to be medically necessary by the plan. Members of specific employer groups may have a copay for specific outpatient procedures.

Co-insurance

Generally, co-insurance is an amount based upon the member being responsible for a percentage of the allowed amount for a covered service. A provider may request payment at the time of service; however, the provider must take care to determine the member's specific benefit and apply any contract reimbursement terms to determine the amount of the co-insurance. At no time should a provider collect more than the amount that is contractually obligated to be paid. The most accurate method to assure that the provider is collecting the correct amount may be to wait for the explanation of benefits (EOB) from The Health Plan showing the amount that is member responsibility. A copy of the EOB is also sent to the member letting them know the amount that is their responsibility.

Deductibles

Deductibles are an annual amount, defined by the member's benefit plan that members must satisfy before the plan pays for any services. A provider may expect payment from the member at the time of service if the member has not satisfied their annual deductible. Unless the member knows that they have not met their deductible, it is generally difficult, due to claims lag, to determine. At no time should a provider collect more than the amount that is the member's responsibility.



Collecting copays when another insurance is primary

If you have questions regarding whether or not to collect an office copay, please contact The Health Plan Coordination of Benefits Department at 1.740.695.7903 or 1.800.624.6961, ext. 7903.

Determining a member's responsibility

Member copays for physician office visits and certain other services may be found on The Health Plan's provider secure portal myplan.healthplan.org or by calling The Health Plan Customer Service Department at 1.800.624.6961.

PLEASE NOTE: Deductible and co-insurance are not applicable for preventive services.

The Affordable Care Act (ACA) requires private insurers to cover certain preventive services without any patient cost-sharing. The Health Plan products affected by the ACA would be our commercial, HMO, PPO, POS, and self-funded employer groups.

Under the ACA, private health plans must provide coverage for a range of preventive services and **may not impose cost sharing (such as copayments, deductibles, or co-insurance)** on patients receiving these services. Please remember that annual well exams and other preventive services do not require a copay or co-insurance from the member, unless the employer group to which they belong is "grandfathered."

Information about Medicare Preventive Services can be found on the [CMS website](https://www.cms.gov).

Section 7

Clinical Services





Clinical Services Introduction

The medical management program ensures the provision of appropriate health care to its members while addressing the effectiveness and quality of the care. The delivery of health care services is monitored and evaluated to identify opportunities for improvement. The program provides for a systematic process to promote the access of medically appropriate, holistic care in a timely, efficient manner across the network through population health-driven care, complex case navigation, prior authorization, admission and concurrent reviews, health and wellness programs, chronic disease management and pharmacy programs.

The primary goal of the medical management program is to measurably improve the utilization of care and services to our members in a way that is financially responsible and responsive to their individual health care needs. This goal is achieved by meeting the following objectives:

- Promote and provide appropriate allocation of health care services to our members.
- Perform utilization management processes with minimal disruption to the delivery of care and services, including clinical information gathering, documentation review, and communication of utilization management decisions.
- Identify members for social service referrals, care navigation assistance, complex case management, and high risk perinatal and chronic disease navigation programs.
- Assess medical management program performance by soliciting input from members and practitioners through surveys annually.
- Develop interventions based on input received from members and practitioners to improve the quality of services to all customers.
- Educate practitioners on the scope of the medical management program and Clinical Services Division.

Medical Prior Authorization & Notification Requirements

The Medical Prior Authorization and Notification Requirements are available [here](#).



Palladian Health

Palladian Health is performing prior authorization and medical necessity review for musculoskeletal conditions and spine pain management.

This change affects all providers treating back pain and musculoskeletal conditions including chiropractors, physical therapists, occupational therapists, surgeons, orthopedists, neurologists, neurosurgeons, pain management specialists and clinics, physiatrists and anesthesia pain management specialists.

Medical necessity review and prior authorizations may be completed through The Health Plan's online provider portal, via fax at 1.844.681.1205 or telephonically at 1.877.244.8514.

Questions on this process may be addressed by calling THP's provider number at 1.877.847.7901 or by contacting your practice management consultant.

As part of our commitment to providing programs that support THP's Population Health Management initiatives, The Health Plan has partnered with Palladian Health to provide an evidence-based approach to coordinating and managing the treatment of musculoskeletal conditions and spine pain. The program focuses on improving health outcomes and ensuring appropriate treatment while engaging patients through a care advocacy program. The care advocacy program includes patient outreach, support and education, provides web-based self-management education, and a cognitive behavioral therapy telehealth program.

Palladian Health performs prior authorization and medical necessity review as follows:

- **All services related to spine care management**, (including injections, spinal surgeries, and spinal stimulation, etc.) require prior authorization and medical necessity review by Palladian Health
 - Includes all commercially insured fully funded plans (including HMO, PPO and POS plans), all Mountain Health Trust (MHT) plans (including WV Medicaid, WV Health Bridge, Supplemental Security Insurance [SSI] and Children's Health Insurance Program [WVCHIP]), and all Medicare Advantage plans (SecureCare HMO, SecureChoice PPO, Dual Eligible Special Needs Population[DSNP]).
 - Participants in self-funded plans are not included in this program
 - Diagnostic imaging reviews, MRI, etc., are reviewed for medical necessity and prior authorized by eviCore health care.
- **PT and OT** – the first 20 **combined** visits for physical therapy (PT) and occupational therapy (OT) per event and/or year do not require prior authorization.
- Palladian Health will review services for medical necessity and determine authorization status beginning with the 21st **combined** PT/OT visit.
- **Chiropractic care** – the first 20 visits for chiropractic services per event and/or year do not require prior authorization
 - Palladian Health will complete medical necessity review beginning with the 21st chiropractic visit.
 - **All x-rays performed in the chiropractic setting require prior authorization**
 - Visit limitations for THP MHT and Medicare lines of business will follow a calendar year.
 - Commercial plan (including HMO, POS, PPO and WV PEIA) visit limitations will be based on a contract year.
 - Self-Funded plans are excluded and default to the group plan document.



eviCore healthcare

The Health Plan has entered into a partnership with eviCore healthcare to manage medical necessity and prior authorization for the following services for all MHT, Medicare and fully insured lines of business. Services performed in conjunction with an inpatient stay, 23-hour observation, or emergency room visit are not subject to authorization requirements.

For urgent requests: If services are required in less than 48 hours due to medically urgent conditions, please call 877.791.4104 for expedited authorization reviews. Be sure to tell the representative the authorization is for medically urgent care.

This prior authorization and review process does not include services provided to participants in self-funded plans. Please check plan benefits for coverage and prior authorization requirements.

- **Sleep Studies**
- **Durable Medical Equipment (DME)**
- **Radiology/Cardiology**
 - CT / CTA
 - MRI / MRA
 - PET / PET CT
 - Myocardial Perfusion Imaging (Nuclear Stress)
 - Echo / Echo Stress
 - Diagnostic Heart Cath
 - Cardiac Imaging (CT, MRI, PET)
 - Cardiac Rhythm Implantable Device (CRID)
- **Post-Acute Care (Medicare/DSNP ONLY)**
 - Skilled nursing
 - Home health (all services)
 - Long term acute care
 - Inpatient rehab

Access to the list of CPT codes that require prior authorization are located at [evicore.com](https://www.evicore.com) along with eviCore healthcare's clinical guidelines and request forms.

Services performed without authorization may be denied for payment, and you may not seek reimbursement from members.



Telephone Directory

| | During Business Hours (8 a.m. to 5 p.m.) | After Hours Urgent/Emergent Issues |
|--|---|---|
| Admissions Benefit/Eligibility Urgent or Emergent Notification UM Support 24/7 Availability – reverts to voicemail after hours | 1.800.304.9101 1.877.794.7152 | 1.866.NURSEHP (1.866.687.7347) |
| Prior authorizations *Online submission for prior authorization is available at myplan.healthplan.org | Fully Funded: 1.888.847.7902 ASO: 1.888.816.3096 Medicare: 1.877.847.7907 MHT (WV Medicaid, WV Health Bridge, SSI and WVCHIP): 1.888.613.8385 Palladian: 1.877.244.8514 eviCore: 1.877.791.4104 | 1.866.NURSEHP (1.866.687.7347) |
| Fax Number – Clinical information for referral review Fax Number – Hospital demographics and clinical reviews | 1.888.329.8471 1.330.830.4397 | |
| Medical Directors | 1.800.624.6961, ext. 7644 | 1.866.NURSEHP (1.866.687.7347) |
| Administrative Assistant | 1.800.624.6961, ext. 7644 | |
| Medical Emergency Nurse Line available 24/7 | 1.866.NURSEHP (1.866.687.7347) | 1.866.NURSEHP (1.866.687.7347) |



Nurse Information Line

There is always access to a nurse navigator to assist practitioners regarding information about the medical management process and the authorization of care.

The nurse information line provides practitioners with access to a nurse navigator 24 hours a day, 7 days a week and has been a feature of The Health Plan since 1994.

You can contact the nurse information line by calling a nurse navigator directly at 1.866.NURSEHP (1.866.687.7347).

Admissions/Concurrent Review Process

Prior authorization of elective admissions is performed to confirm eligibility, benefits, and medical appropriateness of services to be rendered and level of care to be utilized. The process is initiated by the member's primary care physician (PCP) or referring participating specialist with the Medical Department's nurse navigators. This includes acute care, rehabilitation, skilled nursing facilities and long-term acute care facility (LTACF).

Notification of urgent/emergent admissions, by the admitting physician or facility, is required at the time of, or as soon as practically possible after admission into an acute care facility. This activity is performed for early discussion of member's needs as related to the admission or alternative health care services.

All out-of-plan and tertiary non urgent/emergent requests require prior authorization. Clinical information is reviewed for availability of service within the plan's network, clinical complexity, or other extenuating circumstances and should be supplied by the PCP or appropriate in-plan specialist (if referring within their specialty). This includes acute care, long-term acute care facilities (LTACF), rehabilitation, and skilled nursing facilities.

Concurrent review is the process of continued reassessment of medical appropriateness for inpatient care. Any member identified with potential discharge planning needs is referred by the Medical Management Department's inpatient navigator to case navigation, chronic disease navigation or the social workers as appropriate for early intervention. Concurrent review is performed by fax or telephonically and involves communication with physicians, hospital utilization review (UR) staff, social workers and family members as necessary.

The process of concurrent review utilizes nationally recognized criteria for inpatient admissions and continued stay. It is understood that the criteria cannot be applied to all cases. All factors such as the member's age, living conditions, support systems and past medical/surgical history are considered in applying criteria.

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.



30 Day Hospital Readmission Utilization Management Review Guidelines

Policy Overview: This administrative policy is applicable to in-network facilities based on a contracted DRG or case rate methodology for all of The Health Plan's fully funded lines of business and ASO groups or plans utilizing The Health Plan Network at participating network facilities. It defines payment guidelines for readmissions to an acute general short-term hospital occurring within thirty (30) calendar days of the date of discharge from the same acute general short-term hospital for the same, similar or clinically related diagnoses. In the instance of multiple readmissions, each admission will be reviewed against criteria relative to the immediately preceding admission.

Definitions:

- Clinically Related – an underlying reason for subsequent admission that is plausibly related to the care rendered during or immediately following a prior hospital admission. A clinically related readmission may involve the same or similar diagnosis or DRG group and may have resulted from the process of care and treatment during the prior admission (e.g. readmission for surgical wound infection, or readmission for appendectomy following an admission for abdominal pain with fever) or from lack of or improper post admission care coordination (e.g. failure to transmit orders to home infusion provider for antibiotics necessitating readmission) rather than from unrelated events that occurred after the prior admission (e.g. broken leg due to trauma following a medical admission).
- Readmission – an admission to the hospital occurring within 30 days of the date of discharge from the same hospital. For the purpose of calculating the 30-day readmission window the day of discharge is not counted.

Policy Statement

The Health Plan Medical Management Department shall conduct hospital readmission review to determine if the readmission was considered clinically related to the previous admission. Readmissions determined to be clinically related to the previous admission will not be separately reimbursed. Facilities will be notified that readmission authorization is denied for clinically related criteria and the previously approved inpatient authorization will be updated to cover the second stay. Facilities will receive written notice and instructions regarding how to submit a corrected claim.

Clinically Related Criteria:

- A medical readmission for a continuation or recurrence of the previous admission or closely related condition (e.g., readmission for diabetes following initial admission for diabetes)
- A medical complication related to care during the previous admission (e.g., patient discharged with urinary catheter readmitted for treatment of a urinary tract infection)
- An unplanned readmission for surgical procedure to address a continuation or recurrence of a problem causing the previous admission (e.g., readmitted for appendectomy following a previous admission for abdominal pain with fever)
- An unplanned readmission for a surgical procedure to address a complication resulting from care from the previous admission (e.g. readmission for drainage of a post-operative wound abscess following an admission for bowel resection)

** Hospital readmission review determination as described above is specifically to determine if the readmission is clinically related and is not an assessment of medical necessity or appropriateness of setting.*

**Exclusions from hospital readmission review are:**

- Transfers from out of network to in-network facilities
- Transfer of patients to receive care not available at the first facility
- Readmissions that are planned for repetitive or staged treatments, such as cancer chemotherapy or staged surgical procedures
- Readmissions associated with malignancies (limited to those who are in active chemotherapy regimens), burns, or cystic fibrosis
- Readmissions for primary psychiatric disease (thirty (30) day readmission reviews are NOT applied to behavioral health inpatient admissions)
- Relapses for SUD causing readmission
- Readmissions where the first admission had a discharge status of "left against medical advice"
- Readmissions greater than 31 days from the date of discharge of the first admission
- Readmission for patients under 12 months of age at time of service
- Obstetrical readmissions

Refer to **Section 12** for billing guidelines related to inpatient readmissions occurring within 30 days.

Prior Authorization/Referral Management Review Criteria

Nationally recognized clinical criteria are utilized to perform reviews for medical appropriateness allowing for consideration of the needs of the individual member, his/her circumstances, medical history, and availability of care and services within The Health Plan network. Input is sought annually, or as needed, in the review of criteria from physicians in the community and those who serve as members of the physician advisory committee. In cases where specific clinical expertise is needed to perform a review, or an appeal is presented, reviews are sent to a contracted URAC or NCQA accredited vendor for specialty medical review services by board-certified physician reviewers with the same or similar background.



InterQual® Review

The Health Plan utilizes Change Healthcare InterQual® criteria as a screening guideline to assist reviewers in determining medical appropriateness of health care services. Any participating provider/practitioner, upon request, may review the specific criteria used in an active clinical review process of a procedure requiring the use of InterQual®. You may call The Health Plan's Clinical Services Department if you have a general InterQual® question or a question regarding a particular type of care. InterQual® review worksheets are available upon request.

The Health Plan uses InterQual® guidelines for most procedures and services other than for MHT groups where West Virginia's Bureau of Medical Services has mandated use of other criteria for specific services. Refer to The Health Plan's prior authorization list for specific details.

Primary care physicians (PCP) are responsible for directing care to specialty care physicians. The Health Plan does not require a referral to an in-plan specialist in most instances.

Please refer to the complete listing of in-plan services that require prior authorization and/or notification. Remember, additional services may require prior authorization based on specific plan requirements of some groups, especially those that are self-funded. Also, due to changes in medical technology and the accessibility of diagnostic equipment and services in an office/outpatient setting, as well as updated methods or approaches to performing procedures and services, there may be additional services that will require medical review. Contact The Health Plan if you have concern regarding a particular procedure or test.

The Health Plan's most recent prior authorization list can be found on the Secure Provider Portal at myplan.healthplan.org. The prior auth list includes a CPT Code level table for ease of reference. 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.

Please click [here](#) for detailed information.

Providers shall be informed of service and authorization requirement changes (include site of service changes) no less than 30 days prior to the implementation of such changes.

Requests for Second Opinion

Most “second opinion” evaluations may be achieved within the member’s local network. In the event the services requested are not available locally, a tertiary level “second opinion” may be considered.

When requesting a **second opinion at a tertiary facility**, please understand that this request authorizes an **evaluation visit only and that any further visits, surgery, treatment, and testing would require additional prior authorization.**

Once the evaluation is completed, the consulting physician should send his/her report back to the referring physician, who will then discuss findings with the member.



Specialist Coordination of Health Care Services

(Standing Referrals, Specialist Referrals and Secondary Care Providers)

It is the policy of The Health Plan to facilitate ongoing specialist care and coordination of benefits for members with special health care needs. This would apply when the primary care practitioner, in consultation with a specialist practitioner, identifies the need for specialty care for a condition that is life-threatening, degenerative, or disabling.

Specialist Referrals

The PCP is responsible for initiating a specialist referral if one is required by plan design and supplying appropriate member history to the specialist. A treatment plan is formulated by both physicians and the member. The plan of care is subject to review by the Clinical Services Department.

Standing Referral

Ongoing care over an extended period of time is requested on a standing referral. Standing referrals are used to prior authorize episodes of specialty care, support tertiary care requirements or for approved single case agreement provider referrals. The number of visits shall be based upon the treatment plan and shall be limited to a one-year period. Case management is highly recommended for members requiring standing referrals.

Secondary Care Provider (SCP)

When the member's care cannot be delivered in the primary care setting due to complexity of care or due to a particular disease process being the driving force of care, the member may choose to select an in-plan participating specialist as SCP to support or act as their PCP. Examples of a SCP may include endocrinology, oncology, nephrology, gynecology or cardiology. Enrollment in a clinical program such as Case Management or Disease Management is highly recommended for members requiring SCP care direction.

- The SCP is authorized to provide and refer for health care services in the manner of the primary care practitioner, providing the care is relevant to the expertise of the specialist and that the SCP has agreed to act in this role.
- A listed approved SCP will draw the same reduced copay as the PCP if applicable by plan design.

All THP enrollees have access to Advanced Practice Clinicians, such as certified pediatric or family nurse practitioners and certified nurse midwives and may designate them as their primary care practitioner.



Member Wellness, Prevention & Health Promotion

The Health Plan offers an array of primary preventive health interventions to help decrease the incidence or progression of illness and chronic disease. We engage the member in wellness and health promotion activities, such as education, physical activity and health screenings, to encourage a healthy lifestyle.

The Health Plan provides and promotes a health risk assessment (HRA), wellness information, clinical guidelines and other clinical decision-making tools. They are available on our [website](#), secure member portal or interactively by telephone with a health coach or outreach member advocate by calling 1.855.577.7124.

Member Wellness, Prevention and Health Promotion initiatives include:

- Outreach/welcome calls
- Health Risk Assessments with risk stratification to clinical program referrals
- Screening/Periodicity Reminders/Gap in Care Closure Notification and Support/Over and Under Utilization Education
- Trimester Screening and Education Calls
- Risk Reduction Information related to nutrition, exercise, stress management, home safety/falls prevention, safe opiate use and disposal, etc. provided to population health driven focus groups
- Resource Referrals to Outside Supports: Women, Infants and Children (WIC), Food Banks, Birth to Three, Workforce, etc.
- Smoking Cessation

Care Coordination

Care Coordination is a series of supportive services and programs offered to THP members to facilitate quality care planning and improve access to care. It is made up of Complex Case Management, Care Navigation, Disease Management and the Perinatal Care Program.

There is no wrong door for referring members to a Care Coordination Program. Anyone may request evaluation for participation in a Care Coordination Program at any time. Members with any identified needs related to end of life issues, functional deficits, personal resource deficits, benefit issues, poor linkage to care, caregiver issues, or medication issues are appropriate to refer or may self-refer to Care Navigation. Members with specific trigger diagnoses may be appropriate for Complex Case Management. Members requiring education to manage chronic conditions such as diabetes, cardiac, respiratory or high-risk perinatal conditions may be appropriate for Disease Management or Perinatal Care. Members, family members, providers, discharge planners, community service agencies and employer groups may contact The Health Plan to request evaluation for a Care Coordination Program by phone at 1.800.624.6961, ext. 7644 or may submit an electronic request online at healthplan.org.



Care Navigation

Care Navigation is a program for the member requiring support or education to achieve personal health goals on a short-term basis. It is intended to be episodic or situational and care is facilitated by a care navigator. Care navigators can be registered nurses, licensed practical nurses, social workers, licensed professional counselors or medically trained member advocates depending on the nature of the case and member's need. A THP care navigator coordinates resources to support members and minimize costs while improving total quality of care. Care navigation focuses on service access, health maintenance, education and member empowerment through promotion of self-management skills. Medical and behavioral health issues are addressed along with social determinant of health needs to provide the best possible member outcomes.

A Few Common Triggers for Referral to Care Coordination

- Readmissions within 30 days
- Enrollment in a clinical trial
- Redirection of out-of-network or transitional care needs
- Autism support services needed
- ADHD support services or medication management needed
- Suicide or homicide ideation or attempts
- Overdose/Narcan administration
- Admission to crisis stabilization unit (CSU)
- Members with Substance Use Disorder seeking treatment/admission to a residential program
- Acute inpatient psychiatric treatment requiring support
- Individuals with diagnoses likely to represent chronic pain and need for pain management services
- Prescription Lock In identified
- Members diagnosed with complications from COVID-19
- PRTF- Psychiatric Residential Treatment Facility-arranging, coordination and monitoring all medical and support services.
- Acute Behavioral Health or Substance Abuse inpatient stays ages 21 and under

Complex Case Management

The Complex Case Management Program is a service that helps provide appropriate care and supportive services to individual members, their families and/or caregivers on a long-term basis, often for the perpetuity of their time on plan with The Health Plan. Members are identified as high-risk due to catastrophic illness or injury and are enrolled in this program based primarily on a trigger diagnosis or multiple complex diagnoses. Members receive a comprehensive HRA and disease specific assessment performed by a complex case navigator to develop a member centric care plan. Assessments are performed on enrollment and at minimum annually. Complex case navigators are registered nurses with Certified Case Manager credentials (CCM), or they are registered nurses supervised by a CCM. They have a variety of specialty backgrounds and are trained to address medical, behavioral and social needs.

A key aspect of the Complex case navigator's job is to assess the needs of the member from a holistic point of view. A comprehensive assessment helps identify any potential medical/behavioral health needs, safety needs, gaps in care or applicable social determinants of health such as housing or food security that must be addressed in a care plan to help the member to achieve defined



goals. Opportunities, goals and interventions are identified and agreed upon by the member in collaboration with the complex case navigator and their care team members. Care team members may include pharmacists, social workers, counselors, psychologists, THP medical directors, providers and/or family members/caregivers identified by the member or the Complex Case Navigator and added to the care team. . The Complex case navigator serves as the direct contact to coordinate care with all involved care team members and is responsible for scheduling follow up calls and/or visits at routine agreed upon intervals to guide care coordination. Timing of interventions and call frequency is based on individual need, member acuity and agreed upon schedule of interventions.

Complex Case Criteria/Trigger Diagnoses

1. Transplant—organ and bone marrow/stem cell; includes evaluations, pending and post transplants
2. Catastrophic neuromuscular diseases such as multiple sclerosis, myasthenia gravis, amyotrophic lateral sclerosis
3. Brain injury in active treatment
4. Cystic fibrosis
5. New spinal cord injury
6. Critical or major burns (1st or 2nd degree burns) covering more than 25% of adult's body or more than 20% of child's or 3rd degree burns on more than 10% body surface area or burns involving hands, feet, face, eyes or genitals
7. Immunodeficiency
8. Ventilator cases in home setting
9. Major congenital anomalies – atrial septal defect, valve stenosis and atresia, pulmonary artery stenosis, patent ductus arteriosus, craniofacial deformities, myelocystocele, myelomeningocele (such as spina bifida)
10. Premature birth (extreme) 28 weeks or less
11. Complex cancers in active treatment; with anticipated ongoing high-cost care, including myelodysplasia
12. Children with special health care needs (CSHCN)
13. Hemophilia
14. Genetic abnormality with ongoing care, treatment or monitoring
15. Trauma – Complex needs in active treatment
16. Serious and persistent mental illness as evidenced by recurrent non-substance use related psychosis or mania with multiple emergent admissions (more than three admissions for CSU and/or inpatient psychiatric acute care per year)



Chronic Disease Management Program

The Health Plan's Chronic Disease Management (CDM) Program is an education and support program developed to proactively identify populations with, or at risk for, chronic medical conditions. Populations currently being managed include members with diabetes or pre-diabetes, chronic cardiac conditions such as coronary artery disease and chronic heart failure (CHF), major depressive disorder and chronic obstructive pulmonary disease (COPD). The focus of chronic disease management is early identification and educational engagement with a nurse navigator for at-risk members to learn life skills needed to prevent disease progression and knowledge to support self-management.

The Chronic Disease Management Program supports the practitioner-patient relationship and plan of care and emphasizes the prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies.

Program Content

- The program includes **condition monitoring** relevant to the identified disease state or states that is ongoing and proactive.
- **Member adherence** to the provider treatment plan is integral. Members are followed to determine their success with self-management, self-monitoring activities, and medication compliance. Providers are made aware of their member's enrollment in the program and information is shared with providers on the Care Team. Members are called at periodic intervals. Detailed questions are asked about the member's condition and information is gathered regarding health status, treatment plan adherence, functional status, and quality of life.
- **Member education** is targeted at areas of concern based on the findings from a clinical assessment and functional inventory which is used to build a care plan. Ongoing monitoring ensures timely intervention when a change in risk status is identified. The frequency of outbound calls to participants by the nurse navigator is determined by the severity of symptoms. This may result in daily contact in times of high-risk or concern.
- **Closure of care gaps** is a program goal and Disease Management Nurse Navigators work collaboratively with Population Health, members and providers to facilitate preventive screens, routine tests and recommended ongoing monitoring related to particular disease states.

Perinatal Care Program

The perinatal care program is designed to improve pregnancy outcomes, reduce neonatal hospitalizations, and reduce all costs associated with preterm birth and other complications of pregnancy. This is accomplished by providing perinatal education, promoting safe health behaviors, and enhancing the management of maternity care for women identified at high-risk for premature labor and delivery. The Perinatal Care Program is administered by Perinatal Nurse Navigators with a background in Obstetrics, Gynecology, Labor/Delivery/Post-Partum Recovery or care of neonates. Program goals include:

- Reduction in the incidence of preterm births
- Reduction in the incidence of low-birth-weight babies
- Reduction in the number of neonatal intensive care unit days
- Provision of improved perinatal education, promotion of safe health behaviors including depression screening, and enhanced management of maternity care for women identified as high-risk for premature labor and delivery



Program Enrollment

- Referrals may come from the physician, The Health Plan outreach program, self-referral, and claims data. Physicians are provided a perinatal risk screening tool to fill out and forward to The Health Plan.
- The targeted time for enrollment of all members is between 12 to 15 weeks gestation. A telephonic assessment of the clinical and psychosocial status of the member is completed by Perinatal Nurse Navigator at enrollment and again at week 24. Consideration is given to other health conditions. The assessment tool, along with the perinatal risk screen completed by the physician, is reviewed by the nurse navigator. The mother-to-be is placed in the appropriate low-risk pregnancy group or the high-risk pregnancy group to be case managed.
- A late referral education component is available for those women enrolled after 34 weeks gestation. A partial program is offered for those individuals who decline to enroll in the complete program but who want to receive educational materials.

Program Specifics by Line of Business

Mountain Health Trust

The identification and engagement of low risk MHT pregnant women early in pregnancy is performed with the intent of improving the outcome of the pregnancy. Educating the pregnant woman on healthy lifestyle measures reduces risk factors throughout the pregnancy. The low-risk pregnant woman receives an initial assessment, a second trimester assessment, a third trimester assessment, and post-partum assessment conducted by the Outreach Department. The final post-partum call ensures both the well-being of mother and child and their understanding of available plan benefits.

Commercial and Self-Funded Plans

All commercial and self-funded member pregnancies identified by claims data are offered participation in the prenatal program. After the initial assessment is completed, the program nurse navigator contacts the member every four to six weeks to follow-up on their status and provide education for uncomplicated pregnancies. High-risk members in these groups are followed per high-risk protocol.

High Risk Pregnancy Program for All Lines of Business

High-risk pregnancies are monitored and managed by a Perinatal Nurse Navigator as early as possible and continuously throughout the pregnancy. Mothers/families receive general educational mailings and screenings as well as specific educational materials and targeted calls based on assessment findings. All participants receive scheduled calls from the perinatal care nurse navigator at planned intervals related to their specific care plan and needs. The mother baby couplet with risk factors may remain in the program for up to a year after birth depending on specific needs like ongoing support for neonatal abstinence syndrome or substance exposure. The perinatal nurse works closely with Children with Special Health Care Needs to enrollment members with positive screeners. Mothers or babies with care needs extending beyond 1 year postpartum may be referred over for to another more appropriate program

A successful perinatal care program is dependent on the coordination of health care services. The role of the physician is vital, and this program is intended to complement the medical care the member is receiving from her physician. The goal of The Health Plan is to foster a collegial relationship between the physician and the Perinatal Nurse Navigator to coordinate the necessary health care to promote a healthy mother and a healthy baby.



What the Member and Provider May Expect with Any Care Coordination Program Enrollment

- A Care Navigator/Nurse Navigator performs a telephonic assessment to determine the member's needs and opens a case.
- The member will receive an introductory call and letter explaining the program. The provider will receive a copy of the member letter.
- A plan of care is established based on the member assessment. The care plan identifies prioritized opportunities, goals and interventions to facilitate goal achievement. The care plan is available on the secure member portal to the member and their designated care team. The care plan is available to the provider on the provider portal if they are the PCP or SCP on record or if they have formally been added to the "Care Team" in THP's care coordination platform.
- A Care Team is identified/constructed in the platform. It may include the member, their designated support people, and relevant providers. The member has control over who is on their external care team. The PCP is always a care team member with full access to member records on the Secure Provider Portal.
- Agreed upon interventions are carried out by the care team members as discussed during phone interactions and documented in the care coordination platform.
- Reminders are set for telephonic or messaging follow up at agreed upon intervals. Interventions may take the form of providing education, making/facilitating provider appointments, coordinating transportation, explaining benefits, referring to community agencies, transitional care support, caregiver resources, medication adherence and medication reconciliation among others.
- A care coordination case may be closed 1) when all goals are met, 2) if the member chooses to terminate participation in care coordination, 3) if the member becomes non-compliant with the program and no longer participates actively in calls and interventions.
- Note: some members are monitored at a "Following" case level of care when they are 1) unable to be contacted or 2) refuse participation BUT are also noted to have a Complex Case Management Trigger Diagnosis. These members may be re-approached at transitions of care for additional program enrollment consideration based on changes in acuity. Their providers may be approached for coordination of care documentation by a care navigator or nurse navigator to close gaps in care, obtain treatment plans to ensure quality of care or to support reporting for reinsurance purposes.



Advance Care Planning

At the beginning of 2016, the Centers for Medicare and Medicaid Services (CMS) established separate payments for Advanced Care Planning (ACP) services provided to Medicare beneficiaries. This provision allows for effective communication between patients and their providers to plan for the member's future care.

- CPT code 99497- ACP services provided as part of an Annual Wellness Visit (AWV)

**If the ACP is furnished on the same day, by the same provider, the visit is considered a preventive service. Therefore, the deductible and co-insurance are not applied to the codes.*

Provider's Role:

1. Initiate a conversation with all members of The Health Plan over the age of 18.
2. Promote and support THP members' advance care planning. Document if the member does or does not have an advance directive. Provide them with educational material to help them understand the importance of such documents.
3. Honor their wishes as outlined by their advance care plan and do not discriminate against any member based on the existence or content of their advance directive.
4. Transfer any member whose advance directive you refuse to follow.

Compliance with advance directive policies is part of The Health Plan's quality review process. Annual audits will be conducted to ensure compliance.

If the member has signed an advance directive, a copy should be retained in the medical record.

To comply with guidelines, all members of The Health Plan 18 years old or older must have documentation on their chart that advance care planning has been discussed, reviewed, and updated at a minimum of every three years.

State-specific information regarding advance directives and The Health Plan Envelope of Life is available on our [corporate website](#).

Leadership and Committees

CMO and Medical Directors

The CMO and medical directors of The Health Plan provide leadership and direction for all utilization management and quality improvement activities. This team plays an important role in the development of the quality management program and supervises quality improvement plans and initiatives. One of the THP Physicians serves as chairman for each of the following committees:

- Quality Improvement Committee
- Credentialing Committee
- Medical Directors Oversight Committee
- Physician Advisory Committee
- Appeal and Grievance Committees

The medical directors are solely responsible for denials of authorization decisions based on medical necessity. They will communicate with primary care physicians, attending physicians, and specialist reviewers as necessary for case discussions.



Other responsibilities of The Health Plan medical directors include:

- Decision making regarding medical appropriateness of care and services
- Review of ALL appeals
- Physician education regarding practice patterns

One of The Health Plan's medical directors is available 24 hours a day, seven days a week and can be reached for emergencies via The Health Plan Nurse at 1.866.NURSEHP (1.866.687.7347) or during normal business hours toll-free at 1.800.624.6961, ext. 7644.

Physician Advisory Committee

The physician advisory committee is a collaborative committee established to receive input from the physician community to guide The Health Plan in its decision making related to medical policy affecting coverage and reimbursement for physician services and to discuss issues related to relationships and interactions between and among physicians, their patients, and The Health Plan.

These issues may include but are not limited to: (a) improvement of health care and clinical and quality through the establishment of clinical and quality guidelines; (b) improvement of communications, relations, and cooperation between physicians and The Health Plan; and/or (c) matters of a clinical or administrative nature that impact the interaction between physicians and The Health Plan.

In addition, physicians serving the Physician Advisory Committee (PAC) may also serve as specialty reviewers, based on board certification and field of expertise. The PAC additionally provides oversight of the Medical Directors' Oversight Committee (MDOC).

Members of the committee shall include a representative sample of specialty areas that may include family practice, behavioral health, internal medicine, obstetrics and gynecology, orthopedics, pediatrics, surgery and medical sub-specialists. Committee members may be asked to serve consecutive terms.

Meetings may be held as actual onsite meetings at central or regional locations with telecommunications accessibility. PAC members may also review guidelines, InterQual®, and other policy and procedural changes related to his/her expertise via mailings.

Medical Directors' Oversight Committee (MDOC)

The MDOC is comprised of The Health Plan's CMO, medical directors, and various other department leads in Clinical and Pharmacy Services, Quality Improvement and Population Health. The committee provides internal clinical service program and policy review and ensures clinical questions and issues are dealt with in a timely and appropriate manner. The key functions of the committee are to provide oversight to programs within clinical services, assist in identifying trends and practice pattern variations and develop and initiate programs and interventions as needed.

Appeal and Grievance Committees

The Appeal and Grievance committees are composed of Clinical, Operations, Benefit Services, Quality, Compliance and other staff as needed. They are line of business specific for The Health Plan's Commercial, MHT and Medicare lines of business. These committees convene when necessary to impartially discuss and decide upon a request to reconsider coverage determinations when the member and/or provider are dissatisfied.

Pharmacy and Therapeutics Committee (P&T)



The Pharmacy and Therapeutics Committee is responsible for the formulation and adoption of policies regarding the appropriate evaluation, selection, procurement, distribution, use, and safety of drug therapies. The committee recommends and assists in the development of programs and policies for participating practitioners in all areas pertaining to drug therapy for The Health Plan membership. The committee's composition includes physicians, pharmacists, and representation from The Health Plan. The Pharmacy and Therapeutics Committee reports quarterly to the Quality Improvement Committee.

Annual Program Evaluation

The medical management program and the quality management program are evaluated on an annual basis. A written summary is prepared from the evaluation process that includes utilization and quality management activities during the year, achievement of goals, and revisions for the upcoming year.

The annual program evaluation is approved by the Executive Management Team (EMT) and the Quality Improvement Committee.

Forms, Tools and Worksheets

- The Medical Prior Authorization and Notification Form is available [here](#).
- The Molecular Pathology Request Form is available [here](#).

Section 8

Population Health





Population Health Management

The Health Plan has a population health management strategy that identifies and stratifies our enrollment population based on medical conditions, risk factors, and social determinants of health.

Data is reviewed to assist in developing programs to meet the needs of various risk groups and engage both members and providers in improving the overall health of the populations.

The population health management team completes a population assessment by evaluating trends of prevalence and financial burden of medical conditions, both chronic and episodic, utilizing analytical software, claims data, business intelligence reporting and care navigation engagement reporting and outcomes.

The intent of the analysis is to develop specific programs to support the four focus items of population health management:

- Keeping members healthy
- Managing members with emerging risk
- Managing outcomes across healthcare settings
- Managing multiple chronic conditions

Integration of data for this assessment includes medical and behavioral claims and encounter information, pharmacy claims data, laboratory claims, lab values and results. Additionally, information obtained from health risk assessments is analyzed to identify social determinants of health and barriers to care. Electronic health records may also be available through shared portal access with providers. Other various data points include clinical assessments performed by Clinical Services Department nurse navigators and member outreach as well as vendors who may be providing in-home assessments. Data available through licensed software are also incorporated into the analytical process.

The population assessment is completed to determine:

- Needs across The Health Plan service areas
- Members that should be targeted for various care navigation
- Disease management and social services programs
- Whether the current programs are meeting the needs of the population

Included in the assessment is the review of gaps in care related to evidence-based practice as well as member satisfaction with clinical services programs. Data are reported in aggregate and by product line to facilitate an understanding of similarities and differences in health needs and status according to geographical influences. Additionally, further analysis of specific high-risk groups, such as children with special healthcare needs, members with disabilities, and those with severe and persistent mental illness, is completed to ensure the needs of those members are identified.

Examples of social determinants of health that are identified as barriers to care include:

- Transportation and/or lack of transportation
- Mobility issues
- Food insecurity
- Social isolation

The analysis of this comprehensive assessment is shared internally at The Health Plan as well as with network physicians to support alternative payment relationships, including value-based arrangements.



Quality Measures and HEDIS®

Healthcare Effectiveness Data & Information Set (HEDIS®)

The HEDIS® audit contains a core set of performance measures that provide information about customer satisfaction, specific health care measures, and structural components that ensure quality of care. Annually, The Health Plan is required to report quality performance measures set forth by HEDIS, to NCQA, CMS, and BMS.

The HEDIS audit takes place annually between January and June and administrative (claim) data is used when applicable. The Health Plan contracts with an outside vendor to assist with medical record retrieval needed for each of the applicable performance measures. A representative from our vendor may contact the office for chart retrieval or a nurse may need to visit the office. Every effort will be made to coordinate the onsite visit to accommodate the provider and office staff.

To support performance measurement, the Population Health unit produces care gap reports to identify members with gaps in care according to HEDIS quality measures specifications. The Health Plan practice management consultants can distribute these gap reports to primary care physicians. Gap reports are run monthly based on a proactive review of members' claim history. Gap reports can be run by TIN, PCP, or quality measure.

Appropriate coding by measure is outlined in the 2020-2021 Quality Measures and HEDIS Coding Guide. The HEDIS coding guide is updated annually and is available on the THP [corporate website](#), or by request from your THP practice management consultant.

In addition to utilizing care gap reports and the appropriate HEDIS related ICD-10 codes to capture the services rendered, providers can submit clinical documentation for HEDIS measures via fax to the Population Health team at 1.304.433.8208 or by contacting your practice management consultant.

Section 9

Quality Improvement





Introduction

The Health Plan Quality Management Program consists of quality improvement projects and the collection/analysis of data to identify and track quality of care issues or concerns. Interventions are based on recognized industry standards. The outcome of projects is objectively measured.

Goals and Objectives

Demonstrate compliance with external quality management regulators and programs

- The National Committee for Quality Assurance (NCQA)
- Centers for Medicare and Medicaid Services (CMS)
- Qlarant - External Review Organization for WV DHHR
- West Virginia and Ohio Departments of Insurance

Establish standards and processes for measuring and improving the quality of care and services provided to members

- Clinical Care Indicators
 - Medical/Surgical Variance Investigation
 - Behavioral Health Variance Investigation
 - Medicare and Mountain Health Trust (including WV Medicaid, WV Health Bridge, Supplemental Security Income and WV Children's Health Insurance Program) / CMS Driven Investigations
 - Never Events (NE)
 - Hospital-Acquired Conditions (HAC)
 - Health Care-Associated Conditions (HCAC)
- Customer Satisfaction Indicators
 - Member Complaint Investigation
 - Physician Change Report Reviews
- Care and Service Indicators
 - Clinical Practice Guidelines
 - Standards for Patient Records and Access to Care and Services
 - Medical Record Audit
- Quality Management document annual review and revision
 - Quality Management Evaluation
 - Quality Management Program
 - Quality Management Work Plan– The work plan is an annual document that designates each department's quality management priorities for the year and tracks progress towards meeting these goals. The work plan provides detail on the organization's identified priorities and describes the activities undertaken to address the quality and safety of clinical care and members' experience. The Health Plan utilizes the work plan as a method for interdepartmental communication.
 - Quality Management Policies and Procedures

Utilize a multi-disciplinary approach to identify areas where improvement is needed

- Implement and monitor corrective action plans
- Collaborate with nursing, medical directors, and pharmacy
- Demonstrate improvement in the quality of medical care and services provided to members as a result of quality management initiatives



Quality of Clinical Care Indicators

The Quality Management Department monitors quality of care concerns centered on evidence-based guidelines. A nurse quality coordinator performs a root cause analysis on each quality of care concern. If the concern is found to be valid, it is forwarded to the Program Integrity Team to determine reimbursement.

The guidelines used can be found at:

- Agency for Healthcare Research and Quality (AHRQ) for [PSI 90 Patient Safety Indicators](#)
- National Healthcare Safety Network (NHSN) for [healthcare-associated infections](#)
- National Quality Forum (NQF) for [serious reportable events](#)

Customer Satisfaction Quality Indicators

The Health Plan investigates and tracks every complaint, grievance, or report of member dissatisfaction. Member complaints, grievances, and/or dissatisfactions are registered with the Customer Service Department or the Quality Management Department.

Indicators of dissatisfaction include:

- Quality of Care
- Access
- Attitude/Service
- Billing/Financial Service by The Health Plan
- Quality of practitioner office site



Review Process for Clinical and Customer Service Quality Indicators

Anyone within The Health Plan organization can identify a customer satisfaction or quality indicator. When any of these indicators are identified, the potential issue is forwarded to the Quality Management Department. A nurse quality coordinator performs a case analysis on the potential issue and obtains medical records to review. A letter of inquiry may be sent to the facility or practitioner, requesting review or clarification of an issue. The letter may include a request for a written analysis or opportunities for improvement established by the facility or practitioner based on the complaint. The Health Plan is dedicated to ensuring that all federal and state laws, rules, and regulations are compiled in a timely and effective manner, including The Center for Medicare and Medicaid Services (CMS), The Bureau for Medical Services (BMS) and The Department of Insurance.

If The Health Plan decides that a practitioner is practicing medicine in a manner that is not keeping with reasonable and prevailing standards of care, a corrective action plan may be requested. If the Quality Improvement Committee (QIC) determines that corrective action is needed, the practitioner will be notified in writing. Corrective measures may vary according to the situation and might include any or all of the following:

- A written warning to the practitioner
- Discussion with the practitioner
- Placing the practitioner under a focused review per medical record or claim data reviews
- Requiring the practitioner to enter into a preceptor relationship with another practitioner
- Requiring the practitioner to complete continuing medical education specific to the treatment, procedure or service in question
- Setting limitations on the practitioner's privileges or authority to perform specific procedures



Continuity and Coordination of Care

The Health Plan strives to support and enhance the partnership of members and primary care practitioners, to ensure continuity and coordination of care, and member understanding of and participation in their care. All practitioners/providers involved in a member's care must share clinical information with each other and the member in a timely fashion. Most referrals to specialty practitioners or other practitioners/providers must originate with the PCP. Treatment plans should specify an adequate number of direct access visits to specialty practitioners to accommodate the treatment plan's implementation. Members are afforded direct access to behavioral health practitioners/providers. All referral notifications will include a reminder to all parties to share clinical information in a timely fashion.

The Health Plan's policy regarding continuity and coordination of care states that:

- The primary care practitioner (PCP) bears primary responsibility for coordinating the member's overall health care in a manner consistent with the member's own goals and preferences. Most referrals to specialty practitioners or other practitioners/providers must originate with the PCP. Treatment plans should specify an adequate number of direct access visits to specialty practitioners to accommodate the implementation of the treatment plan. Members are afforded direct access to behavioral health practitioners/providers. All referral notifications will include a reminder to all parties to share clinical information in a timely fashion. (Refer also to CL-24).
- Practitioners/providers must document member input in all treatment plans submitted for authorization; Clinical Services/Behavioral Health Services nurse navigators will review treatment plans for such documentation before approving requested services.
- When required, nurse navigators will educate members regarding their rights and responsibilities to provide input to practitioners/providers as to their care preferences, and document such education appropriately.
Nurse navigators will, where appropriate, advise members and practitioners/providers of available training in self-care, health promotion, etc. This advice should include information about non-covered community resources, as well as, The Health Plan coverage for such services as dietary consults, smoking cessation programs, certified diabetic education, home health nurse educators, wound or ostomy care teaching, home infusion services, etc. and are documented.
- The Health Plan does not prohibit a health care professional from advising and advocating on behalf of a member.
- Health care practitioners should provide information about the findings, diagnoses, and treatment options regardless of coverage, so the member has the opportunity to decide among all relevant treatment options.
- The member should be given information about the risks, benefits, and consequences of treatment or non-treatment. They should be provided a choice to refuse treatment and discuss their preferences about failure treatment decisions.
- Nurse navigators will periodically review treatment plans with their members to ascertain progress and compliance. These reviews will be shared with the primary care practitioner, and updated plans requested where appropriate. This process and outcomes are documented.



Standards for Access to Care and Services

| Appointment Accessibility Standards for PCPs | |
|---|---|
| Routine Care | Within 21 calendar days (exceptions permitted at specific times when PCP capacity is temporarily limited) |
| | |
| Adult Urgent Care | Within 48 hours (2 days) |
| | |
| Pediatric Urgent Care | Same day |
| Emergent Care | Immediately (same day) or send to ER or call 911 |
| | |
| Physical Exams | Scheduled within 180 calendar days |
| Preventive/EPSTD Services | Scheduled per EPSTD guidelines and the EPSTD Periodicity Schedule within thirty (30) days |
| Supplemental Security Income (SSI) members | Within forty-five (45) calendar days of initial enrollment THP may facilitate an appointment with the member's PCP |

***In-office waiting for appointments must not exceed one hour from the scheduled appointment time.**

After Hours Accessibility

After Hours/Week-Ends/Holiday Care Accessibility – Primary care physician/practitioner or a designated covering practitioner should be available to The Health Plan members within **one hour** of their leaving a message or contacting the answering service.

Prenatal Care Accessibility

Appointment Accessibility Standards For OB/GYN – An initial prenatal care visit must be scheduled within 14 calendar days of the date when the woman is found to be pregnant. First and second-trimester visits must be scheduled within seven days of the request. Third-trimester visits must be scheduled within three calendar days of the request. For high-risk pregnancies, appointments must be scheduled within three calendar days of identification as high-risk.

Specialty Care

Specialty care providers should provide appointment access within 30 days for new or established patients. Appointment access should be granted sooner for cases where it is medically appropriate or indicated. In-office waiting for appointments must not exceed one hour from the scheduled appointment time.



| Behavioral Health Appointment Accessibility Standards | |
|---|--|
| Initial Visit for Routine Care | ≤ 10 Working days |
| Follow-up Routine Care of an initial visit for a specific condition | ≤ 30 working days (Prescribers) ≤ 20 working days (Non-prescribers) |
| Follow-up after Inpatient Stay | ≤ 7 days after discharge |
| Urgent Care - Experiencing worsening of symptoms or new symptoms, that if not treated, could result in a more intense level of treatment. | ≤ 48 hours |
| Non-Life-Threatening Emergency Care - Extreme emotional disturbance or behavioral distress, considering harm to self or others, disoriented or out of touch with reality, compromised ability to function, or is otherwise agitated and unable to be calmed. | ≤ 6 hours |
| Emergency Services | Immediately |

Section 10

Behavioral Health





Introduction

The Health Plan strives to ensure the highest quality of care for our members. The Health Plan collaborates with providers/practitioners and members to coordinate care. Our staff works directly with providers/practitioners and members to make available resources known within the provider and community network. Our customer service representatives, nurse navigators, and member advocates are available to assist providers/practitioners and members in obtaining and locating needed services.

The Health Plan's nurse navigators, also referred to more familiarly as care managers, blend behavioral components (such as motivational interviewing with disease management and other aspects of medical and behavioral health case management) to address the member holistically to provide the best possible outcomes. The care manager may link the member to primary care, specialty care, and behavioral providers/practitioners, as well as address social determinants of health.

Please refer to **Section 7** for information that may assist providers in obtaining integrated care for their patients.

The Health Plan's 24-hour phone number is 1.866.NURSEHP (1.866.687.7347) for any patient needs. This number is answered by nurse navigators who will be able to assist providers/practitioners and members.

Requests for prior authorization of treatment may be submitted telephonically at 1.877.221.9295, electronically through the secure [provider portal](#) or by fax to 1.866.616.6255. This fax is secure. Forms are available on The Health Plan website.

Behavioral health admissions may be reported by phone to 1.800.304.9101 24 hours a day, 7 days a week (reverts to voicemail after regular business hours).

Information may be emailed to The Health Plan's secure email at behavioralhealthdocuments@healthplan.org.

Remember, The Health Plan does not require prior authorization for crisis encounters or in plan psychotherapy visits. In plan medication management visits do not require prior authorization for any fully funded or governmental line of business. However, prior authorization may be necessary for these and all other services for employer-funded groups *based* on individual plan documents. Behavioral health customer service representatives can be reached by calling 1.877.221.9295 for any questions regarding prior authorization requirements.

Refer to **Section 5** for behavioral health services, prior authorization requirements, covered services and instructions specific to the Mountain Health Trust (MHT) line of business.



Review Criteria

Nationally recognized clinical criteria are utilized to perform reviews for medical appropriateness, allowing for consideration of the needs of the individual member, his/her circumstances, medical history, and availability of care and services within The Health Plan network. Input is sought annually, or as needed, in the review of criteria from physicians in the community and those who serve as members of the physician advisory committee. In cases where specific clinical expertise is needed to perform a review, or an appeal is presented, reviews are sent to a contracted URAC or NCQA accredited vendor for specialty medical review services by board-certified physician reviewers with the same or similar background.

InterQual® Review

The Health Plan utilizes Change Healthcare InterQual® criteria as a screening guideline to assist reviewers in determining medical appropriateness of health care services. Any participating provider/practitioner, upon request, may review the specific criteria used in an active clinical review process of a procedure requiring the use of InterQual®. You may call The Health Plan's Clinical Services Department if you have a general InterQual® question or a question regarding a particular type of care. InterQual® review worksheets are available upon request.

The Health Plan uses InterQual® guidelines for most procedures and services other than for MHT groups for whom West Virginia's Bureau of Medical Services has mandated use of other criteria for specific services (see provider manuals at wvdhhr.org/bms). Refer to The Health Plan's prior authorization list for lines of business other than Mountain Health Trust located at healthplan.org "For Providers," "Prior Authorization and Referrals."

Refer to **Section 5** to receive Mountain Health Trust Behavioral Health specific details.

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.

See *authorization request forms for necessary prior authorization information related to behavioral health services located on the [provider portal](#) under "Forms," "Behavioral Health Forms".*

Behavioral Health Prior Authorization and Notification Requirements

The Behavioral Health Prior Authorization and Notification Requirements are available [here](#).



Review of Inpatient Treatment, Detoxification, Rehabilitation of Substance Use Disorders and Observation

All inpatient services require admission, concurrent and discharge review by The Health Plan. Only elective admissions may require a preauthorization. Admissions to residential facilities for Substance Use Disorder must meet ASAM criteria for the selected level of care and will require authorization. Not all benefit plans will reimburse for residential treatment of substance use disorder, please check with Customer Services if there is a question. Intensive Outpatient Programs and Partial Hospitalization Programs are outpatient services that provide a less intensive level of care and The Health Plan will allow the first 30 sessions free of authorization for in network providers.

Information may be provided to The Health Plan electronically via the secure provider portal, by fax or telephonically. Faxes should be sent to 1.866.616.6255. For telephonic reviews, call 1.877.794.7152. This number reverts to secure voicemail after normal business hours. This information will be accessed by authorized personnel only.

Forms used in requesting authorization for services are available on The Health Plan's [provider portal](#) under "Forms," "Behavioral Health Forms." This information may also be submitted on facility forms.

Reviews are expected on the day of admission with the exceptions described above. If the admission occurs late in the day, on a holiday or weekend, the facility is requested to notify THP immediately and to provide complete clinical on the next working day. When the admission is approved, the date for concurrent review will be established and conveyed to the provider. This does not apply to admission reviews governed by state law. The Health Plan abides by mandated guidelines.

If the information submitted does not meet review criteria for admission and/or continued stay, The Health Plan nurse navigator will forward the clinical information for review to a physician for evaluation. The physician will utilize nationally recognized criteria to provide a clinical review of the case and provide a medical appropriateness determination. A peer-to-peer discussion may be requested of the facility clinical staff with THP medical directors. The provider/practitioner will be notified when a determination is made. If there is an adverse decision, the provider has an opportunity for reconsideration and further review or the member or their designated representative may appeal as per policy for the line of business. A provider may request a peer-to-peer consultation with a THP physician at any time.

Intensive Outpatient Services (IOP)

Intensive outpatient services are an intermediate level of care in which individuals are typically seen as a group and individually at least three times per week, three hours per day, depending on the structure of the program. IOP for WV Medicaid members must be conducted in programs certified by the Bureau for Medical Services. The first 30 sessions are permitted without authorization for in network providers.

- Concurrent reviews may be submitted after 30 sessions for in network providers by fax, phone or electronic transmission.
- If the sessions meet criteria for continued programming, the nurse navigator will continue to allow the course of treatment and inform the facility of the date when the next concurrent review is due. This will continue until discharge.



- Discharge clinical may be submitted in the same manner as admission and concurrent reviews.
- If the reviews do not meet criteria, the information submitted by the facility will be sent for physician review prior to denial of services.
- IOP services for providers not in network, will be reviewed for medical necessity upon admission. Medical necessity will continue to be reviewed through discharge.
- IOP services must be approved for continued stay after the initial 30 sessions. Facilities providing IOP to WV Medicaid members must be certified by the Bureau for Medical Services.

Partial Hospitalization (PH)

Partial hospitalization is an intermediate level of care for behavioral health conditions. Services are rendered by an accredited program in a treatment setting for behavioral health and/or substance use disorder. The program is an alternative to, or a transition for, traditional inpatient care for members with moderate to severe symptoms. Treatment is an individualized, coordinated, comprehensive, multidisciplinary program. Members participate in this structured program up to five days per week, usually four to five hours per day. Medication management is an integral aspect of partial hospitalization services. The initial 30 sessions are permitted without authorization for in network providers.

Facilities are expected:

- After the first 30 sessions, authorizations will be issued for an appropriate number of additional visits. Continuing services must be reviewed concurrently as advised by utilization management.
- If the sessions meet criteria for continued programming, the nurse navigator will continue to allow the course of treatment and inform the facility of the date when the next concurrent review is due. This will continue until discharge.
- Discharge clinical information may be submitted in the same manner as concurrent reviews.
- If the reviews do not meet criteria, the information submitted by the facility will be sent for medical director review to determine medical necessity.
- Partial Hospitalization services for providers not in network, will be reviewed for medical necessity upon admission. Medical necessity will continue to be reviewed through discharge.
- Facilities providing partial hospitalization to WV Medicaid members must be certified by the WV Bureau for Medical Services.

Observation

Observation is a facility-based treatment providing a level of service lower than inpatient, however providing a safe environment to stabilize the member's condition in an emergency situation. After the observation period has expired, if the member is not ready for discharge, he/she will be transitioned to another level of care



Inpatient Acute Psychiatric and Detoxification Services

Inpatient services are acute psychiatric or detoxification services delivered in a psychiatric unit of a general hospital or in a free-standing psychiatric facility. The acute care services provided include assessment, individual and group therapies, medication management and attention to medical problems with all care coordinated by the physician. Inpatient hospitalization is usually a short-term stabilization and treatment of an acute episode of behavioral health problems. Discharge planning for continued treatment is an integral part of acute psychiatric care.

Prior authorization of elective admissions is performed to confirm eligibility, benefits, and medical appropriateness of services to be rendered and level of care to be utilized. The process is initiated by the member's primary care physician (PCP), referring participating specialist or admitting provider/practitioner with the nurse inpatient navigators.

Notification of urgent/emergent admissions by the admitting facility is required at the time of admission. Clinical information is expected within 48 hours of admission. This activity is performed for early discussion of member's needs as related to the admission, alternative health care services and discharge planning. The Health Plan has a process in place for post stabilization care to ensure continuity of care for members requiring post stabilization medical and behavioral care and services out of plan or when network providers are temporarily not available or accessible.

All out-of-plan and tertiary requests require a referral and prior authorization. Clinical information is reviewed for availability of service within the in-plan network, urgent/emergent situation, or other extenuating circumstances and should be supplied by the behavioral health provider/ practitioner.

Concurrent review is the process of continued reassessment of member progress and discharge planning. Any member identified with potential discharge planning needs is referred by behavioral health's nurse inpatient navigator to the complex case nurse navigator, the care navigator or social worker, as appropriate for early intervention. Concurrent review is performed telephonically, by fax or by electronic transmission. For facility convenience, admission and concurrent or discharge review information forms, as well as a substance use disorder forms are available. These reviews involve communication with physicians, hospital UR, social workers, and family members, as necessary. Any time a quality of care issue is identified or suspected, the case is referred to The Health Plan Quality Improvement Department for review.

Inpatient rehabilitation facilities

THP will reimburse for treatment in inpatient rehabilitation facilities such as Substance Use Disorder (SUD) treatment programs, Psychiatric Rehabilitation Treatment Facilities for Medicaid individuals under age 21 (PRTF), for adult psychiatric rehabilitation facilities depending on benefit plan and short-term residential eating disorder programs depending on the terms of a specific benefit plan. All such treatment must meet medical necessity criteria and must be authorized. Admission to a SUD residential program must be authorized within 72 hours and the program must be approved by the Bureau for Medical Services for WV Medicaid members. Please call customer service 1.877.847.7901 to obtain information regarding a member's specific benefit plan.



Outpatient Prior Authorization and Referral Management

Members are afforded direct access to behavioral health practitioners. No prior authorization is necessary for crisis visits or any urgent or emergent service. Authorization is no longer needed for psychotherapy visits if the member group follows The Health Plan prior authorization list.

Psychological testing may be provided without authorization depending on the specific benefit plan.

The charts below explain the unit of service, if it is available via telehealth, if prior authorization is required, and any qualifying conditions that must be met. The practitioner is expected to perform activities that are within their range of practice and competency. Retroactive reviews may be performed at THP choice.

Psychological Testing

| Code | Descriptor | Units of service | Available by telehealth? | Authorization required? | Criteria | Notes |
|-------|--|----------------------------|--------------------------|-------------------------|-----------|---|
| 96112 | Developmental test administration by qualified professional with interpretation and report | First hour | No | No | Interqual | May only be billed one per event, may only be performed once per year per provider without authorization |
| 96113 | Developmental test administration by qualified professional with interpretation and report | Each additional 30 minutes | No | No | Interqual | Billed in conjunction with 96112, may not be billed in conjunction with any other psychological testing code other than 96130 and 96131, once per year per provider without authorization |
| 96130 | Psychological testing evaluation services by qualified health care professional, including interpretation, report preparation and feedback to patient and caregivers | First hour | No | No | Interqual | May be billed in conjunction with other psychological testing codes, maximum one unit, may only be billed once per year per provider without authorization |



Psychological Testing, Cont.

| Code | Descriptor | Units of service | Available by telehealth? | Authorization required? | Criteria | Notes |
|-------|--|----------------------|--------------------------|-------------------------|-----------|---|
| 96131 | Psychological testing evaluation services by qualified health care professional, including interpretation, report preparation and feedback to patient and caregivers | Each subsequent hour | No | No | Interqual | May be billed in conjunction with other psychological testing codes, may only be billed once per year per provider without authorization |
| 96132 | Neuropsychological testing evaluation services by qualified health care professional, including interpretation, report prep, feedback to patient and caregivers | First hour | No | No | Interqual | May be billed in conjunction with 96136 and 96137 once per year per provider without authorization, maximum one event |
| 96133 | Neuropsychological testing evaluation services by qualified health care professional, including interpretation, report prep, feedback to patient and caregivers | Each additional hour | No | No | Interqual | May be billed in conjunction with 96132, 96136, 96137 once per year per provider without authorization |
| 96136 | Psychological or neuropsychological test administration and scoring by qualified health care professional, two or more tests, any method | First 30 minutes | No | No | Interqual | May be billed only once per event, may not be used for administration of screening tools, may be billed in conjunction with any other testing code other than 96112 and 96113 once per year per provider without authorization, maximum one event |



Psychological Testing, Cont.

| Code | Descriptor | Units of service | Available by telehealth? | Authorization required? | Criteria | Notes |
|--------|---|----------------------------|--------------------------|-------------------------|-----------|--|
| 96137* | Psychological or neuropsychological test administration and scoring by qualified health care professional, two or more tests, any method | Each additional 30 minutes | No | No | Interqual | Billed in conjunction with 96136, may be billed in conjunction with any other psychological testing code except 96112 and 96113, may not be used for administration of screening tools, once per year per provider without authorization |
| 96138* | Psychological or neuropsychological test administration/scoring by technician, two or more tests, any method; first 30 minutes | First 30 minutes | No | No | Interqual | May be billed in conjunction with other psychological testing codes |
| 96139 | Psychological or neuropsychological test administration/scoring by technician, two or more tests, any method; | Each additional 30 minutes | No | No | Interqual | May be billed in conjunction with other psychological testing codes |
| 96146 | Psychological or neuropsychological test administration, with single automated instrument via electronic platform, with automated result only | Event | No | No | Interqual | May be billed in conjunction with other psychological testing codes |
| 96116 | Neurobehavioral status exam, administration, face to face time with patient and time interpreting test results and preparing report | Event | No | No | Interqual | One per six months per provider without authorization, must be performed by qualified professional |

* Not a covered Medicaid benefit

*** Non par providers must submit authorization request for all services.



Applied Behavior Analysis (ABA)

| Code | Description | Units of service | Available by Telehealth? | Provider Type | Description of Service | Prior Auth Required? | Notes |
|-------|---|------------------|--------------------------|---------------|---|----------------------|--|
| 97151 | Behavior Identification Assessment | 15 min | No | BCBA, BCaBA | Professional level assessments; development of the ABA plan per professional guidelines as outlined by the BACB; Limited: non-face to face service; analyzing past data submitted to the current BACBA or BCaBA to incorporate successful and unsuccessful behavior protocols | No | F:F, 1:1, 32/units/day and/or 160 units /week, 40 hours/week in combination with all other ABA designated codes except H0031 |
| 97152 | Behavior Identification supporting assessment | 15 min | No | RBT/BAT | Basic assessments administered by a technician working under the direction and supervision of a BCBA/BCaBA; Face to Face with the patient, technician only | No | F:F, 1:1, 32/units/day and/or 160 units /week, 40 hours/week in combination with all other ABA designated codes except H0031 |



ABA, Cont.

| Code | Description | Units of service | Available by Telehealth? | Provider Type | Description of Service | Prior Auth Required? | Notes |
|-------|--|------------------|--------------------------|---------------|--|----------------------|--|
| 97153 | Adaptive behavior treatment by protocol by an RBT/BAT (paraprofessional) | 15 min | No | RBT/BAT | Direct ABA treatment implementation, by protocol per the prior authorized treatment Plan; implementation through activities per ABA Plan as documented in a prior authorization plan | No | F:F, 1:1, 32/units/day and/or 160 units /week, 40 hours/week in combination with all other ABA designated codes except H0031 |
| 97154 | Group Skills Training and Dev. | 15 min | No | RBT/BAT | Direct ABA treatment plan implementation by protocol per the prior authorized ABA Plan by qualified technician (RBT/BAT); Technician must be under the supervision of a BCBA/BCaBA; Code is for paraprofessional work only | No | F:F, 1:2-3, 32/units/day and/or 160 units /week, 40 hours/week in combination with all other ABA designated codes except H0031 |
| 97155 | ABA Treatment - Adaptive Behavior Treatment | 15 min | No | BCBA/BCaBA | ABA Treatment with protocol modification; resolves one or more problems with the protocol; includes simultaneous direction of the technician; face to face | No | F:F, 1:1, 32/units/day and/or 160 units /week, 40 hours/week in combination with all other ABA designated codes except H0031 |
| 97156 | ABA Treatment - Family Adaptive Behavior Treatment Guidance | 15 min | No | BCBA/BCaBA | Guidance provided to the family to continue implementation at home with patient present identifying potential treatment targets (elimination of maladaptive behaviors); Face to face with parent/guardian and/or primary caregiver training; One professional's service provided to one patient family | No | F:F, 1:1, 32/units/day and/or 160 units /week, 40 hours/week in combination with all other ABA designated codes except H0031 |



ABA, Cont.

| Code | Description | Units of service | Available by Telehealth? | Provider Type | Description of Service | Prior Auth Required? | Notes |
|-------|---|------------------|--------------------------|---------------|---|----------------------|--|
| 97158 | ABA Group Treatment - Adaptive Behavior Treatment | 15 min | No | BCBA/BCaBA | ABA Treatment with protocol modification; such as adjusts the treatment techniques during group sessions; protocol adjustments are being made in real time. | No | F:F, 1:2-3 service. 32/units/day and/or 160 units /week, 40 hours/week in combination with all other ABA designated codes except H0031 |



Professional Services

| Code | Descriptor | Units of service | Available by Telehealth? *** | Requires Prior Authorization | Criteria | Notes*** |
|-------|---|------------------|------------------------------|------------------------------|----------|---|
| 90791 | Psychiatric Diagnostic Evaluation | Event | Yes | No | N/A | Max. two Events per year by same provider/entity, must be performed by physician, physician extender, Lic. Psychologist, LICSW or LPC |
| 90792 | Psychiatric Diagnostic Evaluation w/ med serv | Event | Yes | No | N/A | Max two Events per year by same provider/entity, must be performed by physician or physician extender |
| 90832 | Individual Psychotherapy | 16 to 37 min. | Yes | No | N/A | Physician, physician extender, and independently enrolled Lic. Psychologist, LICSW, LPC, LCSW, LGSW |
| 90833 | Individual Psychotherapy as add on to E/M codes | 16 to 37 min. | Yes | No | N/A | May be performed by physician or physician extender only |
| 90834 | Individual Psychotherapy | 38 to 52 min. | Yes | No | N/A | Physician, physician extender, and independently enrolled Lic. Psychologist, LICSW, LPC, LCSW, LGSW |
| 90836 | Individual Psychotherapy as add on to E/M codes | 38 to 52 min. | Yes | No | N/A | May be performed by physician or physician extender only |
| 90837 | Individual Psychotherapy | 53 plus min. | Yes | No | N/A | Physician, physician extender, and independently enrolled Lic. Psychologist, LICSW, LPC |
| 90875 | Individual Psychotherapy with Biofeedback | 30 min. | No | No | N/A | Physician or Physician extender only |
| 90876 | Individual Psychotherapy with Biofeedback | 45 min. | No | No | N/A | Physician or Physician extender only |
| 90853 | Group Psychotherapy | Event | Yes | No | N/A | Physician, physician extender, and independently enrolled Lic. Psychologist, LICSW, LPC, LCSW, LGSW. Max 12 per group |
| 90839 | Psychotherapy for Crisis | 60 min. | No | No | N/A | Physician, physician extender, Lic. Psychologist, LICSW, LPC only |



Professional Services, Cont.

| Code | Descriptor | Units of service | Available by Telehealth? *** | Requires Prior Authorization | Criteria | Notes*** |
|--|---|------------------|------------------------------|------------------------------|----------|--|
| 90840 | Psychotherapy for Crisis each additional 30 minutes | 30 min. | No | No | N/A | Physician, physician extender, Lic. Psychologist, LICSW, LPC only |
| 90846 | Family Psychotherapy without Patient | 45 to 50 min. | Yes | No | N/A | Physician, physician extender, Lic. Psychologist, LICSW, LPC only |
| 90847 | Family Psychotherapy with Patient | 45 to 50 min. | Yes | No | NA | Physician, physician extender, and independently enrolled Lic. Psychologist, LICSW, LPC only |
| Evaluation And Management Codes | | | | | | |
| 99205 | New Patient | Event | Yes | No | N/A | Physician, physician extender |
| 99211 | Est. Patient Simple | Event | Yes | No | N/A | Physician, physician extender |
| 99212 | Est. Patient Problem Focused | Event | Yes | No | N/A | Physician, physician extender |
| 99213 | Est. Patient Expanded | Event | Yes | No | N/A | Physician, physician extender |
| 99214 | Est. Patient Moderate | Event | Yes | No | N/A | Physician, physician extender |
| 99215 | Est. Patient High Complexity | Event | Yes | No | N/A | Physician, physician extender |
| 96372 | Injection | Event | No | No | N/A | Physician, physician extender |
| 90833 | Therapy add on 30 minutes | Event | Yes | No | N/A | Physician, physician extender |
| 90836 | Therapy add on 45 minutes | Event | Yes | No | N/A | Physician, physician extender |

*** All licensed clinicians billing in a group or physician practice must be credentialed by THP. Please review THP policy regarding ability to bill under physician NPI.

*** Non par providers must submit authorization request for all services.



Remember that additional services may require prior authorization based on specific plan requirements. Some may require prior authorization for all services (i.e., ASO depending on group plan documents).

There may be additional services that will require medical director review. Contact The Health Plan if you have a concern regarding a particular procedure or test.

All out-of-plan and tertiary requests require a referral and prior authorization. Clinical information is reviewed for availability of service within the in-plan network, urgency/emergency of the situation, or other extenuating circumstances. This information should be supplied by the behavioral health provider, PCP or appropriate in-plan specialist (if referring within his/her specialty).

Authorization may be obtained via telephone, fax, website or electronic submission. Copies of all treatment request forms are included in the prior authorization section to assist you in obtaining prior authorization for these services. These forms are available on the secure [provider portal](#). They may also be submitted directly from the website or printed and faxed or mailed in for review. Additional services that require prior authorization include procedures that may have limited coverage under the plan benefit. Also, high-cost procedures and new technologies that have specific coverage guidelines should be prior authorized to assure medical appropriateness and compliance with established standard of care guidelines. Please contact The Health Plan Clinical Services Department if you have any concern regarding coverage of any service.

Any referral that does not meet medical appropriateness review by the nurse navigator is referred to a medical director for review determination. The medical director may contact the behavioral health provider for case discussion. Availability of services within the provider network and alternative levels of care for services may be offered as appropriate to the member's needs.

Services that require a prior authorization are listed on The Health Plan Behavioral Health Services prior authorization list.

Please indicate if your request is emergent so that we may expedite the review. Simply scheduling the test/procedure does not warrant an expedited review. Unless an emergency, scheduling should be done after the service is approved by The Health Plan.

Retroactive reviews for utilization: The Health Plan reserves the right to conduct clinical and utilization management reviews retroactively on a random or targeted basis to ensure that the member met medical necessity criteria for the service in question and to review the quality and appropriateness of the service provided.



Drug Screening and Testing

Please be advised that 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 made 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 located on the [ASAM website](#).

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 affects the following lines of business: Commercial, Mountain Health Trust (including WV Medicaid, WV Health Bridge, Supplemental Security Income, WV Children's Health Insurance Program) and 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.



Credentialing and Billing

The Health Plan requires credentialing of all independently licensed behavioral health practitioners operating within a physician's practice.

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 our Mountain Health Trust members. A supervised psychologist must appear on the web page of the Board of Examiners of Psychologists in WV located [here](#).

Please note that this policy does not apply to physician's offices within Licensed Behavioral Health Centers. Although the billing procedures described below do not apply to FQHC/RHC, the requirement for credentialing does apply to these agencies.

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. Our authorization list is available on the [website](#) under the "For Providers" section.

The Health Plan defaults to CMS policy as interpreted for Medicare for our Commercial plans unless the plan description specifies otherwise. If there is a question regarding this, please contact THP's Customer Service Department.

Medicare and Most Commercial Plans

The Health Plan conforms to Medicare billing requirements for behavioral health "incident to" services provided by a physician. A very concise summary of these requirements was developed by the [National Council for Behavioral Health](#).

To summarize: if a licensed behavioral health practitioner is employed or contracted by a physician whose scope of practice includes behavioral health, the licensed behavioral health practitioner may bill using the physician's NPI, with no modifiers. Examples of such rendering practitioners would include: LICSW, Psychologist, LCSW, LGSW, and LPC. Certified Addictions Counselors may also bill under the physician's NPI if the scope of the service provided is consistent with the counselor's certification.

As a reminder, any staff person providing services incident to physician's services must be credentialed with The Health Plan.

To further clarify, if a physician is federally certified as a Medication Assisted Treatment provider, regardless of the physician's specialty, the physician may have behavioral health practitioners employed or contracted in his office billing incident to the physician's services only so long as the service being provided relates to the physician's practice as a MAT provider if the physician's specialization is not traditionally behavioral health (examples: anesthesiology, internal medicine). A psychiatrist may employ or contract with a behavioral health licensed practitioner to provide a much broader range of services than MAT.

The supervising physician must see the patient initially for assessment and must order the treatment in the patient record as an aspect of the patient's plan of care. The supervising physician must provide regular reviews of the patient's status which must be documented in the patient's record.

Medicare will reimburse "incident to" claims at 100% of the established Medicare rate for the service. Conversely if the licensed behavioral health practitioner is listed on the claim as the rendering



provider, the claim will reimburse at 85% of the established Medicare rate. All services must be provided at place of service 11, clinic.

Mountain Health Trust

For information regarding guidelines for billing under the physician or physician extender's NPI, in conformity with Mountain Health Trust requirements, please see **Section 5** of this manual.

The Health Plan utilizes the following methodology for applications for credentialing all providers: WV Standardized Credentialing Application found on [CAQH](#) or [WV Department of Insurance](#).

Be aware that this will require that the rendering provider have an individual National Provider Identification Number (NPI). A provider may obtain an NPI number on the [NPPES website](#).

Should you have any questions regarding these instructions please feel free to contact the Customer Service Department at 1.888.613.8385 or the practice management consultant assigned to your county. You may access contact information for practice management consultants at: [healthplan.org](#) "For Providers," "Overview."

Providers should be aware that commercial and self-insured policies may vary. Please call our customer services line at 1.877.221.9295 should there be questions regarding these types of policy coverages.

The Health Plan will conduct routine post payment reviews on billings described above. Providers suspected of improper billing may be subject to requests for prior authorization in future and/or may be reported to The Health Plan's Special Investigations Unit for fraud, waste and abuse. New network providers may be requested to submit planned procedures for prepayment review. All out of network providers are required to submit all procedures for prior authorization.

Annual Program Evaluation

The Health Plan's utilization management program and the population health-driven, care continuum quality management program are evaluated on an annual basis. A written summary is prepared from the evaluation process that includes utilization and quality management activities during the year, achievement of previously identified goals, and revisions of goal statements for the upcoming year.

The annual program evaluation is submitted to, and approved by, the Executive Management Team (EMT) and the Quality Improvement Committee.



Access to Care

To comply with NCQA standards, The Health Plan holds to the following standards for access to care for behavioral health cases:

- Practitioners/providers should provide care within six hours in an emergent, non-life-threatening situation.
- Practitioners/providers should provide care within 48 hours of a request for service when the need is urgent.
- Practitioners/providers should provide a follow-up appointment within seven days of discharge from an inpatient facility.
- Practitioners/providers should provide a new routine office visit within 10 working days of request.
- Prescribing practitioners/providers should provide a follow-up visit within 30 working days of the initial visit.
- Non-prescribing practitioners/providers should provide a follow-up visit within 20 working days of the initial visit.

If the practitioner/provider is not available, the member should be made aware of how to access care. This would apply to after hours and weekend coverage as well as other situations.

Continuity and Coordination of Care

The Health Plan Clinical Services Department advocates continuity and collaboration of care between behavioral health and physical health practitioners/providers. Continuity and coordination is an important aspect in the delivery of quality health care as behavioral and medical conditions interact to affect an individual's overall health. Information is expected to be exchanged between behavioral and physical health care providers whenever clinically appropriate.

It is the responsibility of the behavioral health practitioner/provider to communicate with the PCP and the PCP to communicate with the behavioral health practitioner/provider. Any information that is shared between practitioners/providers should be maintained in the member's medical record. If assistance is required to facilitate this exchange of information to ensure care coordination, the Clinical Services Department is available to provide this service (see [Section 7](#) Care Coordination).

All federal and state confidentiality laws should be followed. The Health Plan expects that 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 secure [provider portal](#) for use in facilitating integrated communication.



Behavioral Health Services Forms

The following forms are provided to assist practitioners/providers in requesting services for patients and providing information necessary for continuity and coordination of care. Behavioral health prior authorization and review forms can be transmitted to The Health Plan via the provider secure web portal. These transmissions are received in a secure, restricted fax management queue. The forms listed below are available online at myplan.healthplan.org. Prior authorization requests are also accepted telephonically, electronically, by fax or by email to behavioralhealthdocuments@healthplan.org. Admission, concurrent, and discharge reviews may be called to the nurse inpatient navigator.

- Authorization to Disclose Health Information to PCP
- Admission Review Form
- Concurrent or Discharge Review Information Form
- Continuity of Care Consultation Form
- Psychological Testing Prior Authorization Request Form **
- Treatment Continuation Request Form
- Substance Use Disorder Clinical Review Information Form (for non-MHT)
- Universal Substance Use Disorder Clinical Review form for Medicaid Member Services
- Prior authorization of Drug Screening (labs)
- Request for ACT Programming – WV Medicaid Line of Business only
- Peer Recovery Support Services authorization request (WV Medicaid Line of Business only)
- Request for ECT
- IOP/PHP Request for Authorization **
- Applied Behavior Analysis Initial Authorization request **
- Applied Behavior Analysis Continued service request **

** Required for all out of network providers however not required for many lines of business for in network providers, please call customer service if you have a question about a particular benefit.



Telehealth Services

Telehealth services will be paid to behavioral health practitioners/providers when face-to-face services are not feasible. Services that are eligible for telehealth include, but are not limited to, psychotherapy, pharmacological management, diagnostic interview, and neurobehavioral status exam.

Practitioners/providers who are eligible to provide telehealth include, but are not limited to, licensed psychiatrists, psychiatric nurse practitioners, clinical nurse specialists, physician assistants, licensed clinical psychologists, licensed professional counselors and therapists, and clinical social workers.

The Health Plan follows Medicare criteria for telehealth services for all lines of business, with the exception of our WV Mountain Health Trust product line. WV BMS policies are followed for the WV Mountain Health Trust product line.

Telehealth services must be conducted through the use of an interactive audio and video telecommunications system that permits real-time communications between the practitioners/providers and the member in a secure manner compliant with federal and state privacy regulations. The telecommunication equipment must be of a quality to adequately complete all necessary components to document the level of service for the CPT or HCPCS codes to be billed. The equipment utilized must be HIPAA compliant and meet current Medicare and WV Mountain Health Trust standards.

Follow-Up Care after Behavioral Health Admissions

It is extremely important in the care of those with behavioral health conditions, to receive timely follow-up care after discharge from an in-patient stay. The HEDIS® standard is for the member to be seen by a provider/practitioner within seven days of discharge.

The Health Plan is asking for your cooperation and assistance to achieve this important goal.

We would appreciate your facilitating this by:

- Communicating to the hospital discharge planners that follow-up appointments should be scheduled within seven days of discharge.
- Faxing a member's discharge instructions to our Utilization Management Department at 1.866.616.6255 if you are a facility provider so that we may help to reinforce your discharge plan.
- Communicating to the scheduling staff in your office that it is imperative to schedule appointments for discharging patients within seven days of discharge.
- If you require assistance in this process, please contact our Clinical Services Department for a health care navigator.



Standards and Guidelines of Care

The Health Plan has adopted nationally recognized guidelines to assist our providers/practitioners in providing care to our members. These guidelines address the treatment of depression, the treatment of substance use disorder and guidelines for the diagnosis, evaluation and treatment of ADHD in children and adolescents. Links to these guidelines are posted on The Health Plan [website](#).

These guidelines have been approved by The Health Plan's Physician Advisory Committee, Medical Director Oversight Committee and the Executive Management Team.

If you have any questions regarding these guidelines, call the Clinical Services Department at 1.800.624.6961, ext. 7644.

Section 11

Pharmacy Services





Introduction

The Health Plan shall promote optimal therapeutic use of pharmaceuticals by encouraging the use of cost effective generic and/or brand drugs in certain therapeutic classes.

The Health Plan has processes in place that explain how members, pharmacists, and physicians determine which medications are covered under the members' pharmacy benefit, any utilization management requirements and where members can fill medications.

1. The Health Plan publishes a prescription formulary at least annually for all lines of business and posts the formularies on our [corporate website](#). The formulary includes listings of generic, brand and specialty drugs that are available through the pharmacy benefit. The formulary indicates a drug's copay tier as well as utilization management requirements including prior authorization, step therapy or quantity limit requirements.

In therapeutic classes where The Health Plan has preferred drugs for the treatment of certain diseases, only those drugs are to be used. The Health Plan has utilization management criteria in place to steer members to preferred drugs. The Health Plan publishes the utilization management criteria on the [provider portal](#) for our prescribers. In cases where the physician has written a prescription for a drug not on the formulary or for a drug that requires authorization, the dispensing pharmacist will contact the prescriber to change the medication, if possible, to a preferred drug in the class. Therapeutic substitution is only permitted with authorization by the prescriber in the form of a new prescription.

2. Where state pharmaceutical dispensing laws permit, the pharmacy is encouraged to dispense generic forms of prescribed drugs. Only generic drugs that are listed in the FDA "orange book" as being therapeutically equivalent to the innovator product (brand) are required to be dispensed as a generic drug. This is also known as "AB" rated.

The Health Plan pharmaceutical management program allows consideration of medical necessity exceptions for members in obtaining coverage for non-preferred drugs and brand drugs when a generic is available.

3. Prescriptions can be filled at any participating THP pharmacy within the member's pharmacy network. THP does reserve the right to redirect medications to a specific pharmacy such as a specialty pharmacy for certain medications. Any medication redirection will be communicated to providers via the authorization notification letter.



Clinical Criteria for Pharmaceutical Management Program

The Health Plan's pharmacy benefit manager utilizes standard criteria to construct the formularies for each line of pharmacy business managed by The Health Plan. The clinical criterion used is taken from relevant clinical literature.

1. **Quality Criteria:** After FDA approval, each drug is reviewed with regard to its: therapeutic indications, efficacy, dosage frequency, adverse events, therapeutic index, potency, and any compliance factors.
2. **Cost Analysis:** Each drug is reviewed with regard to its cost in comparison to any formulary alternative in its class. If there is no formulary alternative, the drug is placed on the formulary. If the drug under review has a lower cost alternative, continued review is indicated.
3. **Quality vs. Cost:** Other cost considerations are examined and include a pharmacoeconomic perspective that evaluates drug therapy cost-effectiveness as it relates to physician visits, patient costs, emergency room visits, laboratory costs, hospitalizations, and sick days.
4. **Special Considerations:** Criteria is in place for prior authorization of identified drugs, education of physicians and members, drug inclusion in clinical guidelines, and placement of quantity limits on drugs dispensed.
5. **Clinical Literature:** This is used in every decision to add or exclude pharmaceuticals on the formulary. Clinical evidence shall come from appropriate government agencies, medical associations, national commissions, peer-reviewed journals, and authoritative compendia.

Pharmacy and Therapeutics Committee

The Pharmacy and Therapeutics Committee develops policies and procedures for the utilization management of prescription drugs for The Health Plan. These policies and procedures are designed to enhance the appropriate use of prescriptions in both a clinical and cost-effective manner.

Specialty Pharmacy Program

Specialty drugs are high-cost, high complexity or high touch medications. Specialty drugs are used to treat very specific diseases and require extensive management for safety and effectiveness. Dosages need to be monitored for effect and adjustments might be needed for adequate response to effectively treat the disease.

Specialty drugs require prior authorization to ensure an appropriate candidate for the drug. Additionally, oversight is an integral part of the prior authorization process. Dispensing might be limited to pharmacies with specific skills and distribution programs to ensure proper delivery of these medications. Diseases targeted to receive therapy include, but are not limited to, rheumatoid arthritis, severe chronic psoriasis, multiple sclerosis, hepatitis C, hemophilia, certain cancers, growth deficiency, cystic fibrosis, Crohn's disease and organ transplant.

Coverage for these agents are provided under the members' Specialty Pharmacy Benefit. The list of specialty drugs is available on the [corporate website](#) under "For Providers" "Prior Authorization and Referrals"



Pain Management Program and Opiate/Opioid Management

The Health Plan limits the acute use of opioid medications for moderate to severe pain from acute injury, medical treatment or surgical procedure for fully insured and employer funded members. The first fill of an opioid medication will be limited to a 5-day supply. This limit is for the first fill of an opioid medication for a member who has no history of opioid usage in the past 130 days.

For those members needing further management of their pain, a prior authorization will be required if:

- The opioid exceeds 80 morphine milligram equivalents
- Is taken for greater than 90 consecutive days
- Is a long acting opioid
- Is being taken with a medication that could cause respiratory depression.

A pharmacist will review the case to evaluate that the opioid is being utilized safely and appropriately. Additionally, the member can be limited to one prescriber and one pharmacy, if needed.

Formulary medications will be preferred over non-formulary medications. Step therapy rules will be applied when reviewing a request for non-formulary medications. Also, dosing and quantities may be limited.

Obtaining a Prescription

Locating a Pharmacy in The Health Plan Network

A THP member may obtain a prescription at any participating THP pharmacy. For the location of a participating pharmacy, call our prescription benefit manager at 1.800.988.2262 or expressscripts.com. The member's THP ID card must be presented to the pharmacist to allow dispensing of the prescription. The member may be required to pay a copayment which will be collected at the time of service based on the prescription drug plan of the member.

Choosing a Preferred Formulary Drug

Formulary Tier Definitions

- Prescription – Drugs that can only be dispensed upon order (prescription) by a qualified provider of care. Additionally, only drugs which are labeled “Caution: Federal law prohibits dispensing without a prescription” will be considered eligible.
- Generic – A drug available as a chemically and therapeutically equivalent copy of a brand name drug. It is usually available from several manufacturers. Generics must meet federal standards for potency and bioavailability.
- Brand Drug – A prescription item only available from a single source supplier.
- Multi-Source Brand Drugs – Brand name drugs which are manufactured by more than one producer. These agents are usually available as generic equivalents.
- Over-the-Counter Drugs (OTC) – Drugs which are not restricted to prescription-only status. These agents are available for purchase without physician approval and are not covered by THP.
- Home Delivery Service – Certain group benefit designs allow members to receive medications at home via the mail. (See your specific benefits for details).

Pharmaceutical Substitution and Interchange Program



Where state pharmaceutical dispensing laws permit, the pharmacy is encouraged to dispense generic forms of prescribed drugs. Only generic drugs that are listed in the FDA “orange book” as being therapeutically equivalent to the innovator product (brand) are required to be dispensed as a generic drug.

Generic Difference Policy

If a prescription order specifies that a brand name drug must be dispensed when the generic equivalent is available, or the prescription order allows for generic substitution and the member elects to have the prescription filled with a brand name drug instead, the member must pay the brand copayment plus the difference between The Health Plan cost of a brand name and its generic equivalent (i.e., The Health Plan only pays for the generic cost.) *Please note non-formulary brand versions of generic drugs require coverage review.*

Pharmacy Prior Authorization and Notification Requirements

Pharmacy Pre-Authorization and Notification Requirements are available [here](#).

Formulary

The Health Plan formularies are a listing of prescription medications that are preferred for use. Formulary drugs will be a covered benefit when dispensed at participating pharmacies. Drugs not listed are not covered without written medical statements of necessity by the prescribing physician. Coverage requests may be requested non-urgently or urgently. Requests for non-urgent coverage determinations received after 5 p.m. will be processed the next business day. All requests for coverage determinations will be processed within the applicable state, federal or accrediting agency timeframes.

Multi-source drugs must be dispensed as the generic. Failure to dispense the generic will subject the member to a higher copayment. This higher copay consists of the brand copayment plus the cost difference of the brand drug and generic drug.

Non-Formulary Requests (Exception Policy)

Certain non-formulary medications are eligible for coverage only after a patient-specific approval has been authorized. Patient-specific criteria may include age, gender, and clinical conditions determined by the physician for authorization to be granted for a specific drug. A non-formulary exception request can be made by the member, member's representative or physician. A Formulary Exception Request Form may be accessed on THP's secure [provider portal](#) “Forms,” “Other Forms” or by contacting Pharmacy Services at 1.800.624.6961, ext. 7914. Exception requests may be requested non-urgently or urgently. Requests for non-urgent exceptions received after 5 p.m. will be processed the next business day. All requests for exceptions will be processed within the applicable state, federal or accrediting agency timeframes.

The Health Plan Pharmacy Service Department is available Monday through Friday 8 a.m. to 5 p.m. and after hours via telephonic auto attendant's emergency option seven days a week, including holidays. They may be reached at 1.800.624.6961, ext. 7914; fax 304.885.7592.



Requests will be reviewed according to the following criteria:

1. The request for the non-formulary drug is for a condition or medical need not met by existing drugs on The Health Plan formulary.
2. In the physician's medical judgment, the formulary alternatives have been ineffective in the treatment of the member's disease or condition (documentation in the member's clinical record is required).
3. The formulary alternative causes, or is reasonably expected by the prescriber to cause, a harmful or adverse reaction in the member (documentation in the member's clinical record is required).

Authorization for Coverage

Authorization for coverage consists of rules-based programs for determining whether members qualify for coverage of a requested drug based upon the plan's predefined benefit criteria. Predefined benefit criteria are based on recommendations of The Health Plan's Pharmacy and Therapeutics Committee. These rules are periodically reviewed for appropriateness.

Mandatory Generic Policy and Formulary Override Procedure

Pharmacy benefits with a mandatory generic component require that if the prescription item ordered is available from a generic supplier, The Health Plan will cover the maximum allowable cost of the generic. Any additional costs of brand name medication will be the responsibility of the member. This is regardless of any dispense as written indicators (DAW).

Exemption Review Request Procedure

At the time of dispensing, the pharmacist will transmit a claim to The Health Plan claims processor. If the item submitted is available as a generic, the claims processor returns the cost of the prescription in the following manner:

| Brand submitted | Generic submitted |
|--|---|
| The brand copay is assessed + the difference in the cost of the generic and brand product to arrive at a brand penalty copayment. Copay = brand copayment + penalty | The generic copayment is assessed, and it is the member's responsibility to pay at the time of dispensing |

Exemptions

The following agents are exempt from mandatory criteria:

Generic drugs not listed in the FDA "orange book" of generic equivalents with an "AB" rating. "AB" rating is defined as therapeutic and generic equivalent.

In cases of defined medical necessity, an exemption to the mandatory generic policy may be authorized. Exemption requests can be called to pharmacy services at 1.800.624.6961, ext. 7914 or faxed to 304.885.7592.

The requests must include:

- Supporting medical literature describing treatment failures of the generics.



- Defined allergic potential to a specific component in a generic NOT found in the brand product. (i.e., fillers, dyes, preservatives)
 - Documented treatment failure of a specific member with supporting clinical assessment and appropriate lab readings.
 - Member refusal to take the generic is not acceptable.

Prior Authorizations

Program Description

The Health Plan Pharmacy Services Department handles customer service calls and coverage review determinations as well as eligibility and prior authorization updates.

Traditional Prior Authorization (TPA)

A program where The Health Plan Pharmacy Services Department adjudicates coverage review determinations as well as authorization updates. This program criteria is developed and conforms to plan coverage conditions for client review and selection and in administering prior authorization protocols. Traditional prior authorization rules require coverage review for all claims presented for a given drug to determine if the member qualifies for coverage for use of the drug, based upon The Health Plan's pre-defined benefit criteria.

Smart Rules – Automated Prior Authorization Processes at the Point of Sale

Smart rules use sophisticated logic in conjunction with available medical history, drug history, patient reported health information, and medical claims information to determine whether or not a member qualifies for coverage for use of a drug based on the plan's pre-defined benefit criteria. Smart rules and the pharmacy benefit manager's system capabilities allow coverage management programs to more efficiently qualify for coverage of those claims that are consistent with the benefit. As a result, smart rules limit reviews for coverage to only those claims where the member's request is least likely to be appropriate for coverage. Authorizations for coverage smart rule capabilities include qualification or disqualification by medical and prescription history.

Qualification-by-history logic searches the member's history for the presence of data that will qualify the member for coverage without a requirement for coverage review. Only that member for whom such data is absent requires review for coverage. Disqualification-by-history logic searches the member's history for the presence of data that will disqualify the member for coverage without a requirement for coverage review. Only those members for whom such data is present require review for coverage.



Authorizing Amount of Coverage

Authorization of amount for coverage is a collection of rules-based programs for determining whether members qualify for coverage of the full amount of drug requested based on the plan's pre-defined benefit criteria. Authorization of amount for coverage programs use smart rule logic to determine if members qualify for coverage for medications beyond drug-specific thresholds for a quantity, dose and/or duration deemed reasonable for most uses.

Quantity Per Dispensing Event

Quantity per dispensing event rules set dispensing quantity thresholds that reduce client exposure to unnecessary cost, without creating obstacles to access for the vast majority of users. In addition, through coverage review and traditional prior authorization, members can be qualified for additional coverage where warranted by special circumstances and consistent with the intent of the benefit.

Prior Authorization Forms

Prior authorization forms can be found on The Health Plan's secure [provider portal](#).

Section 12

Billing





Billing Procedures

The Health Plan prefers and encourages electronic claim submission. If you choose to submit claims in paper form, all paper claims and supporting documentation should be submitted to:

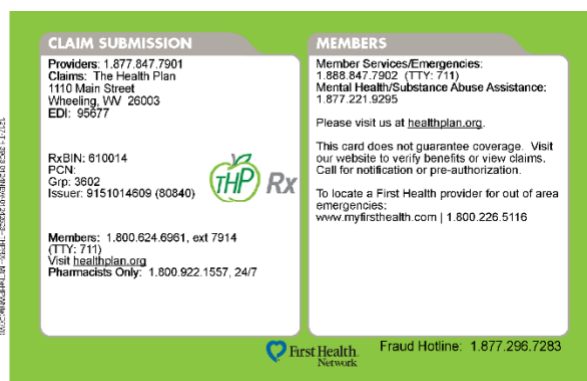
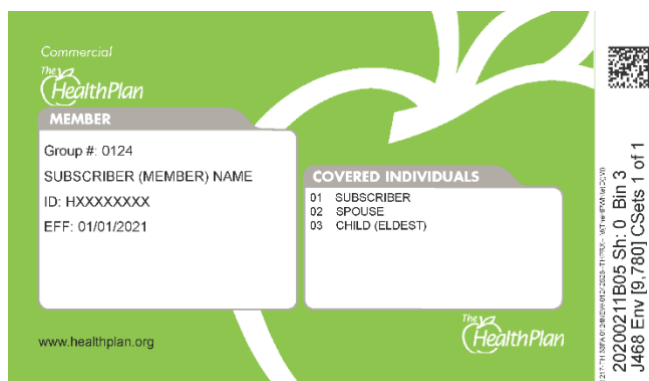
The Health Plan
1110 Main Street
Wheeling, WV 26003

Only original claim forms (red ink) will be accepted. Handwritten claims, copies made from an original claim form, faxed or scanned claims (black ink) will be rejected. As an alternative to paper claims, providers may submit claims electronically, free of charge, via The Health Plan's provider portal, myplan.healthplan.org. Contact your practice management consultant to learn how to utilize the portal. Practice management consultant contact information is located on our [website](#).

Claim forms must be completed in their entirety. The efficiency with which the claim form is completed directly affects the efficiency with which the claim is processed for payment. Submitting a clean claim ensures timely and appropriate processing of payment. A clean claim is defined as one that can be processed without obtaining additional information from the provider of the service or from a third party. This definition does not include a claim from a provider who is under investigation for fraud or abuse, or a claim review for medical necessity.

The Health Plan requires that all claims are submitted with accurate and current **CPT-4**, **HCPCs**, and **ICD-10** codes, as appropriate. For each procedure that is listed on the claim a diagnosis code (ICD-10) must support the services (listed in block 24D on the CMS 1500 form) to ensure expeditious and accurate processing of the claim. You must relate the diagnosis (es) listed in block 21 to the individual service lines. You need **ONLY** to relate diagnosis A, B, C, etc. **NOT** the ICD-10 code in block 24E. **THP encourages the use of category II codes to report performance measures. Use of category II codes will decrease the need for medical record abstraction and chart review.**

- The Health Plan accepts the standard current billing forms: the CMS 1500 (02/12) professional claim form, UB-04 hospital claim form and the ADA dental claim form.
- When utilizing the member ID number on the billing form, indicate the entire number, including the nine-digit ID number and two-digit suffix as shown on The Health Plan ID card below. Do not use dashes or spaces.
- The patient ID number starts with the letter H, the remaining eight digits are numeric. The suffix identifies the family member. (Example: 01 – Subscriber, 02 – Spouse, 03 – Child [eldest])



Timely filing limit is 180 days from the date of service.



Coordination of benefits (COB) claims (where another carrier has primary responsibility for making payment), must be submitted within 180 days from the date of service or 90 days from the date of the primary carrier's explanation of benefits (EOB). If you do not receive payment or rejection from the primary carrier and the 180-day time limit is approaching, you must bill The Health Plan before the 180-day deadline, whether or not you have received the EOB from the primary carrier.

All claims are paid within 30 days from the date of receipt by The Health Plan or as otherwise required by prompt pay requirements. If a clean claim is not paid within the applicable timeframes, appropriate interest will be applied to the claim when it is paid as required by state law, Medicare or Mountain Health Trust (MHT). For MHT services including WV Medicaid, WV Health Bridge, Supplemental Security Income (SSI) and West Virginia Children's Health Insurance Program (WVCHIP), interest will be paid to in-network providers at 18 percent per annum calculated daily for the full period the claim remains unpaid beyond the 30-day clean claims payment deadline.

Payment and payment vouchers are available electronically or mailed by request bi-monthly, depending on the line of business. Refer to **Section 12** for information regarding electronic remittance.

Questions concerning payment or denial must be submitted to The Health Plan within 180 days from the payment/denial date of the claim or 180 days from the date of service. Refer to **Section 15** for additional information on claims resubmission procedures.

The provider should collect applicable deductible, copayments, or co-insurance at the time of service whenever possible. Copayments may not be waived (with the exception of COB) as this is in direct violation of the physician contract with The Health Plan.

The Health Plan members are NOT to be billed directly or balance billed for covered services.

Determining a member's responsibility

Member copays for physician office visits and certain other services may be found on The Health Plan's provider secure portal myplan.healthplan.org or by calling The Health Plan Customer Service Department at 1.800.624.6961.

PLEASE NOTE: Deductible and coinsurance are not applicable for preventive services.

The Affordable Care Act (ACA) requires private insurers to cover certain preventive services without any patient cost-sharing. The Health Plan products affected by the ACA would be our commercial, HMO, PPO, POS, and self-funded employer groups.

Under the ACA, private health plans must provide coverage for a range of preventive services and **may not impose cost sharing (such as copayments, deductibles, or co-insurance)** on patients receiving these services. Please remember that annual well exams and other preventive services do not require a copay or coinsurance from the member, unless the employer group to which they belong, is "grandfathered."

Information about Medicare Preventive Services can be found on the [CMS website](https://www.cms.gov).



The Health Plan will NOT reimburse physicians, nor can the member be billed, for the following services:

- Canceled/missed appointments
- Completion of paperwork
- Educational services
- False information/fraudulent billing
- Making referrals
- Mileage
- Never events/avoidable hospital conditions/provider preventable conditions
- Normal postoperative care
- Phone calls
- Phone consults
- Prescriptions
- Services not rendered
- Stat charges
- Unnecessary services not indicated by diagnosis

Changes in reimbursement/fee schedules issued by federal and/or state entities will become effective by The Health Plan on the date of notification. Refer to **Section 5** for policies regarding changes to MHT fee schedules.

The Health Plan requires prior authorization for all elective admissions. Hospitals are required to contact our utilization department to provide clinical and demographic information to ensure criteria is met. The hospital is then given a census number which will be different than the prior authorization number. Claims cannot be processed if there is not a census on file for ALL elective admissions, including those that were prior authorized. Failure to obtain a census number will result in a denied claim.



Never Events and Avoidable Hospital Conditions

Never Events

Wrong procedures, or procedures performed on the wrong side, wrong body part, or wrong person, are commonly referred to as "never events." These never events are not medically necessary as they are not required to diagnose or treat an illness, injury, disease, or its symptoms and are not consistent with generally accepted standards of medical practice. All never events involving a wrong procedure, or a procedure performed on the wrong side, wrong body part, or wrong person are considered not medically necessary, and reimbursement is not permitted. Hospitals generally refrain from billing members for these never events. In the instance where The Health Plan does receive bills for such services, these shall appropriately be denied for lack of medical necessity.

Avoidable Hospital Conditions

Avoidable hospital conditions (a.k.a. hospital-acquired conditions) are conditions "which could reasonably have been prevented through application of evidence-based guidelines." These conditions are not present when patients are admitted to a hospital but present during the stay.

Effective October 1, 2008, the Centers for Medicare and Medicaid Services (CMS) identified the following as preventable hospital acquired conditions:

- Air embolism
- Blood incompatibility
- Catheter-associated urinary tract infection
- Deep vein thrombosis and pulmonary embolism following certain orthopedic procedures.
- Falls and trauma
- Foreign objects retained after surgery
- Manifestations of poor glycemic control
- Mediastinitis, following coronary artery bypass graft (CABG)
- Pressure ulcers stages III and IV
- Surgical site infection following bariatric surgery for obesity; and
- Surgical site infection following certain orthopedic procedures
- Vascular catheter-associated infection and surgical site infection

CMS provided that effective October 1, 2007, hospitals should begin submitting inpatient hospital charges with a present on admission (POA) indicator. POA is defined as a condition that is present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including the emergency department, observation, or outpatient surgery are considered as POA.

The Health Plan reviews and tracks admissions with identifiable never events and avoidable hospital conditions. When it is determined there were additional hospital inpatient days at a participating provider facility, which directly and exclusively resulted from an avoidable hospital condition (not present on admission), reimbursement for additional inpatient days and/or services may be denied. Further, avoidable hospital conditions and never events shall not be considered in DRG determinations for facilities reimbursed through a DRG methodology. Denials for inpatient hospital days or services which are the result of such circumstances are not billable to the member. These reimbursement denials will not apply to hospital admissions in which the avoidable hospital condition



was present on admission, or where another secondary diagnosis is a major complicated/comorbidity (MCC) or complication/comorbidity (CC) in addition to the POA diagnosis, and potentially impacted the avoidable hospital condition.

Never Events Codes/Hospital-Acquired Conditions/Healthcare Associated Conditions

| Codes | Events | Examples |
|-------------|--------------------------|--|
| NA | Preventable | Unintended retention of a foreign object in a patient after surgery or other invasive procedure. |
| NB | Serious Preventable | Any death or serious injuries associated with intravascular air embolism that occurs while being cared for in a healthcare setting. |
| NC | Serious Preventable | Patient death or serious injury associated with unsafe administration of blood products or the administration of incompatible blood. |
| ND | Catheter | Urinary tract infections associated with a catheter. |
| ND | Pressure Ulcers | Stage III & IV (decubitus ulcers) acquired after admission/presentation to a health care setting. |
| NF | Vascular | Catheter associated infection |
| NG | Surgical Site Infection | Mediastinitis within 30 days of coronary artery bypass surgery (CABG). |
| NH01 | Hospital-Acquired Injury | Falls and fractures |
| NH02 | Hospital-Acquired Injury | Dislocations |
| NH03 | Hospital-Acquired Injury | Intracranial injury |
| NH04 | Hospital-Acquired Injury | Crushing injury |
| NH05 | Hospital-Acquired Injury | Burns |
| NH06 | Hospital-Acquired Injury | Other unspecified effects of external causes |
| NH07 | Hospital-Acquired Death | Postoperative death of a healthy patient (ASA Category 1). |



| Codes | Events | Examples |
|-----------|---|--|
| NI | Poor Glycemic Control | Diabetic ketoacidosis, non-ketotic hyperosmolar coma, hypoglycemic coma, secondary diabetes with ketoacidosis, secondary diabetes with hyperosmolarity |
| NJ | Surgical Site Infection | An infectious or inflammatory reaction due to the implant of an orthopedic device following specific orthopedic procedures (spine, neck, shoulder, elbow) within 365 days. |
| NK | Surgical Site Infection | Surgical site infection within 30 days of bariatric surgery for obesity (laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery) |
| NL | DVT/PE | DVT or PE following specific orthopedic procedures (total knee/hip replacements), or a DVT that has occurred in an acute hospital and is diagnosed during the hospital stay. |
| NM | Surgery/Invasive Procedure NEVER EVENT | A surgery or invasive procedure on the wrong body part. |
| NN | Surgery/Invasive Procedure NEVER EVENT | A surgery or invasive procedure on the wrong patient. |
| NO | Surgery/Invasive Procedure NEVER EVENT | Wrong surgery/invasive procedure performed on a patient. |
| NP | Surgical Site Infection | Surgical site infection following a cardiac implantable electronic device (CIED). |
| NQ | Iatrogenic Pneumothorax | Iatrogenic pneumothorax caused by the diagnosis, manner, or treatment of a physician (i.e., inserting venous catheterization). |

When any of the above variance codes are identified, a case is generated. Each case is assigned a number, and medical records are ordered to be reviewed. A written evaluation of findings is created, and cases may be reviewed at an interdisciplinary team meeting. If immediate review is necessary, the situation is immediately brought to the attention of the medical director.

Never events, hospital acquired conditions (HACs), and healthcare associated conditions continue to be investigated by The Health Plan. Any of the diagnoses or conditions that are clearly documented as present upon an inpatient admission are not preventable by CMS guidelines.



Electronic Billing – Documentation Submission

To assist with the submission of required documentation for claims adjudication, The Health Plan has a dedicated fax line to submit your documentation. The fax number is 740.699.6163.

In order to assure the required documentation is routed correctly, you must accurately complete The Health Plan fax cover sheet in its entirety. A copy of the Fax Cover Sheet to Support Electronic Claim Submission is available [here](#). Failure to complete the fax cover sheet may result in claim denials. A separate fax cover sheet is required for each document faxed.

*Your electronic claim should be marked in the **claim note** or **claim line** area with notification stating additional documentation has been faxed. Placing the word **FAX** in the **claim note** area will alert our claim reviewers.*

You must fax all required documentation within 24 hours of your electronic claims transmission.

Notice of Readmissions Review Occurring Within 30 Days

Attention Hospital Providers

Effective November 1, 2018, all clinically related /potentially preventable readmissions occurring within a thirty (30) day period are subject to review. Readmissions will be denied when any of the following are determined:

- A patient was prematurely discharged from the same hospital,
- A facility failed to have proper and adequate discharge planning in place, OR
- If there was a lack of proper coordination between the inpatient and outpatient healthcare teams.

In order for proper payment to occur, providers are required to follow the below guidelines:

- Hospital readmissions within 30 days for the same or similar diagnosis/DRG should be billed and paid as one claim.
- The hospital should combine both inpatient admissions on one claim and bill a corrected claim using bill type 117 in Box 4 on the UB04 claim form
- The index admission date should be placed in Box 12 on the UB04 claim form
- Combine the appropriate number of observation and inpatient days for the index admission and the readmission
- In Box 42 on the claim form, enter 180 (or the appropriate leave code) and appropriate service units (Box 46) to account for the days between the admission and the readmission when the member was not receiving services. \$0.00 should appear in Box 47 "Total Charges;"
- To resubmit a hospital claim electronically:
 - Indicate the original claim number in Loop 2300, Segment REF02
 - Indicate 6 (corrected claim) for the Claim Frequency Code in Loop 2300, Segment CLM05-3
- Once the corrected claim is received by THP, the index admission payment will be reversed, and the corrected claim will be reviewed and processed.

Final review decisions will be made/confirmed by an employed medical director of THP.

Refer to [Section 7](#) for more information on the 30-day hospital readmission review guideline.

Questions regarding claim denials may be directed to the Customer Service Department at 1.800.624.6961.

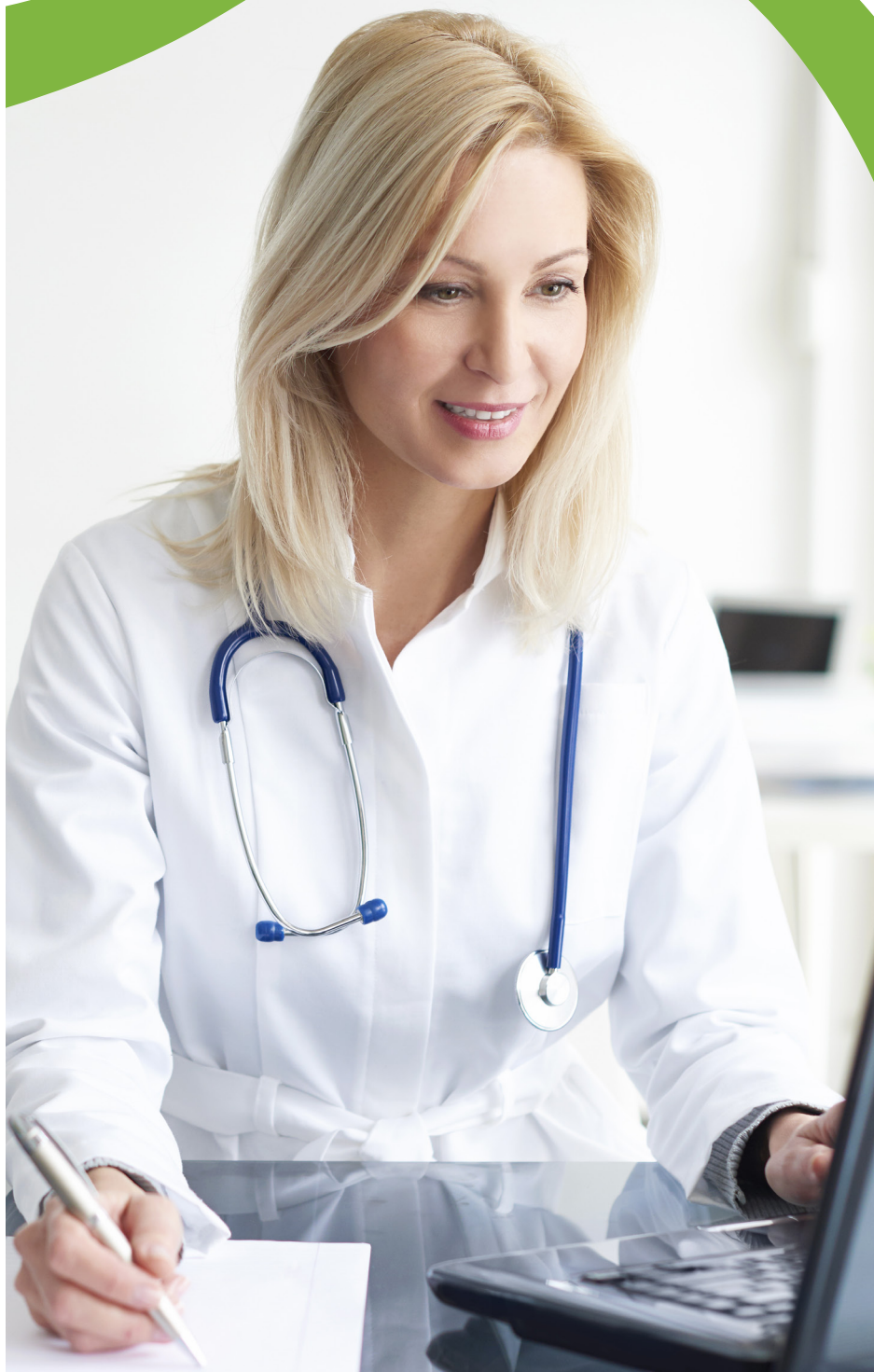


Disputes and Arbitration

In the event of any dispute between THP and a contracted provider with respect to the performance or interpretation of any of the terms of their Agreement, including but not limited to disagreements over the amounts of compensation paid, the parties shall attempt to resolve such matter. In the event THP and contracted provider are unable to resolve a dispute to either party's satisfaction, all matters in controversy shall be submitted to binding arbitration under the auspices, rules, and regulations of the American Arbitration Association after exhaustion of internal remedies provided by THP. Such arbitration shall be initiated by either party making a written demand for arbitration on the other party. The parties agree to be bound by the decision of the arbitrator and accept any decision by the arbitrator as final determination of the matter in dispute. The parties will divide the costs of arbitration equally.

Section 13

EDI





Introduction

The Health Plan makes various methods of electronic data information (EDI) available to providers.

- Access the secure provider portal at myplan.healthplan.org. The provider portal requires an email and password for health care providers.
The provider portal includes helpful information, such as:
 - Claim status and submission
 - Member eligibility and benefits
 - Pre-authorization status and submission
 - PCP patient rosters
 - Payment vouchers
- Participating Clearinghouses
- Direct FTP connection
 - Electronic Claims Submissions/837
 - Electronic Payment Vouchers/835/ERA
 - Eligibility HIPAA 270/271 Filing
- Direct Deposit

If you cannot find what you are looking for on our website, please contact:

EDI Support Center
The Health Plan
1110 Main St.
Wheeling, WV 26003
Telephone: 1.800.624.6961



THP Trading Partner Electronic Submitters

National Payer ID: 95677

| CLEARINGHOUSE | PAYER ID |
|-----------------------------|-----------|
| Apex EDI | 95677 |
| Alveo/Consult ECP | HPUOV |
| Availity | 95677 |
| CPSI/Trubridge | CPSINET |
| ClaimLogic | HPUOH |
| Claim Source | 270704425 |
| Cortex | CX029 |
| Emdeon* | 34150* |
| eSolutions | 481213987 |
| Etactics | UOVOH |
| Gateway EDI/TriZetto | 00162 |
| Healthcare IP | |
| MD Online/Ability | 15THP |
| MedAssets/ nThrive/ Visient | |
| MTBC | |
| Office Ally* | 34150* |
| Optum* | 34150* |
| PNC | 10060 |
| Practice Insight | HPUOV |
| Quadax | NHPL |
| RelayHealth/McKesson | 95677 |
| Rocket System Laboratory | |
| SSI Group | 95677 |
| ZIRMED/Waystar | 10060 |

*Electronic voucher 835/ERA not available

Updated 06/2020

Section 14

Coordination of Benefits (COB)





Coordination of Benefits (COB)

COB is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for medical treatment. COB is designed to eliminate the opportunity for a person to profit from an illness as a result of duplicate group health care coverage. By allowing two or more insurance carriers to work together, the insurance companies can ensure that claims are divided fairly and can avoid paying the same medical bills twice.

COB and Employer Group Contracts

Each employer group contracting with The Health Plan has a COB provision in their contract. In accordance with your provider contract, claims for members with another insurance should be submitted to the primary carrier first for payment.

Definitions

- Primary plan – plan that reviews for payment first
- Secondary plan – plan that reviews for payment second

When The Health Plan is Secondary

In accordance with your contract, when The Health Plan is the secondary payer, The Health Plan will consider the balance of covered services not paid by the primary plan, so long as the total payment does not exceed 100 percent of the rates agreed to in your contract.

National Association of Insurance Commissioners (NAIC) COB Calculation

Some lines of business follow NAIC guidelines for COB calculation. In determining the amount to be paid by the secondary plan on a claim, should the plan wish to coordinate benefits, the secondary plan shall calculate the benefits it would have paid on the claim in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed 100 percent of the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

Mountain Health Trust Members

For members that have primary insurance coverage from a source other than Mountain Health Trust (MHT), THP will honor coverage and utilization management decisions made by the primary carrier for those services in the primary carrier's benefits package. If THP is responsible for MHT, including WV Medicaid, WV Health Bridge, Supplemental Security Income (SSI) and WV Children's Health Insurance Program (WVCHIP) services that are carved out of the primary carrier's benefit package, THP has utilization management responsibility for those carved out services.



Order of Benefit Determination Rules

Non-Dependent or Dependent: The plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber, or retiree, is the primary plan and the plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent, and primary to the plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, policyholder, subscriber or retiree is the secondary plan and the other plan is the primary plan. Example below:

- **Employee:** The plan covering the person as an employee pays benefits first. (If the patient is our subscriber The Health Plan is primary.)
- **Spouse:** The plan covering that person as a dependent pays benefit second. (If the patient is the spouse of our subscriber, The Health Plan is secondary to the spouse's insurance.)

Dependent children: The plan covering the parent whose birthday falls earlier in the year is determined before those of the plan of the parent whose birthday falls later in that year. The term "birthday" refers only to the month and day of birth during the calendar year. (If both parents have the same birthday, the benefits of the plan that covered the parent the longest is the primary plan.)

Dependent children of separated or divorced parents: When parents are separated or divorced, the birthday rule applies when the court decree does not designate a specific parent to carry insurance for the child as primary. However, if specific terms of a court decree state that one parent is responsible for the health care expenses of the child, the plan of that parent is primary.

In the absence of a court decree, the following rules apply:

- a. The plan of the parent (with custody) who is the residential parent and legal custodian of the child pays first.
- b. The plan of the spouse of the parent (with custody) who is the residential parent and legal custodian of the child pays next.
- c. The plan of the parent (without custody) who is not the residential parent and legal custodian of the child pays next.
- d. The plan of the spouse of the parent (without custody) who is not the residential parent and legal custodian of the child pays last.

Active/inactive employee: The primary plan is the plan that covers a person as an employee who is neither laid off nor retired, or that employee's dependent. The secondary plan is the plan that covers that person as a laid-off or retired employee, or the employee's dependent. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the non-dependent or dependent rule can determine the order of benefits.

Longer/shorter length of coverage: If none of the above rules determines the order of benefits, the plan covering a person longer pays first. The plan covering that person for the shorter time pays second.



Procedures Regarding COB

COB Billing Procedures

- Bill the primary insurance first even if there is a deductible to be met so that the service can be applied to the deductible.
- Bill the secondary insurance and attach the primary explanation of benefits (EOB) to expedite payment from The Health Plan.
- If billing electronically, COB information must be included in the electronic submission.
- If billing on paper, a separate EOB must be submitted for each claim
- All payments indicated on the claim must be supported by an EOB or the claim will be denied.
- All prior authorization requirements apply when billing The Health Plan as secondary.
- DO NOT highlight on claims or inquiries. Please underline or star items that you wish to bring to The Health Plan's attention.

Reminder: The Health Plan is always primary over Mountain Health Trust, including WV Medicaid, and WV Children's Health Insurance Program (WVCHIP).

COB Denials

Each COB claim is reviewed to determine whether The Health Plan is primary. If you receive a COB denial (listed below), please resubmit accordingly, based on the denial, for The Health Plan to review again.

- When sending documentation to the attention of the COB Department, please indicate if you have previously spoken to a representative at The Health Plan.
- For questions regarding your voucher or disputes related to COB, contact the COB Department at 1-800.624.6961, ext. 7903.
- All other voucher questions should be directed to the Customer Service Department at 1.800.624.6961



| Type | Description |
|------|---|
| C | Other insurance primary |
| CB | Explanation of benefits required for paid amount shown. |
| CD | Improper primary carrier denial code – primary carrier requesting additional information from provider |
| CF | Incorrect EOB attached (e.g., patient name does not appear on EOB or DOS/charges on EOB disagree with claim). |
| CG | Require explanation/definition of primary carrier's denial remarks/reason code |
| CHS | Member has enrolled in Hospice. |
| CI | Member did not follow primary carrier guidelines; therefore, service is non-covered by The Health Plan. |
| CJ | This code/charge did not appear on EOB. Resubmit with EOB that corresponds. |
| CK | FOR MOUNTAIN HEALTH TRUST (MHT) MEMBERS ONLY Member did not follow primary carrier guidelines; therefore, service is non-covered by (MHT) |
| COB | Other insurance primary –Mountain Health Trust Member |
| U | Workers' compensation primary (for hospital claims) |
| UU | Workers' compensation primary (for ancillary claims) |

Timely Filing as Secondary

Submission for timely filing after receiving primary payment should be submitted within 90 days of primary payment with the primary carrier's EOB.

Note: Self-funded lines of business default to individual group policy requirements regarding timely filing.

Members with Double THP Coverage

- Bill the copay, deductible, and/or co-insurance shown on the payment voucher by using the member's secondary ID number.
- Attach a copy of the voucher showing The Health Plan's payment.

Medicare Primary

Any physician who has submitted an assigned claim to Medicare has agreed to accept Medicare's reasonable charge as payment in full for his services. Per Medicare's Carriers Manual, section 3045.1, the physician is in violation of his signed agreement if he bills or collects from the enrollee and/or the private insurer an amount which, when added to the Medicare benefit received, exceeds the reasonable charge. The Health Plan, as a supplemental insurer, is functioning as a private insurer. Therefore, we will be reimbursing the physician on any services covered by The Health Plan, provided such co-insurance amount *does not* exceed The Health Plan's normal fee.

The Health Plan will pay deductibles, copayments, co-insurances, and other member responsibility amounts not paid by the primary carrier so long as the total payment does not exceed the amount The Health Plan would pay as the primary carrier. This process is applied to each individual service.



Members on Medicare

Below are steps to follow when billing for a Medicare member:

1. **REGULAR MEDICARE (red, white and blue card):** The Health Plan evaluates primary and secondary coverage with Medicare in accordance with the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982. Please call the COB Department at The Health Plan at 1.800.624.6961, ext. 7903 for clarification of primary responsibility for Medicare members with this ID card.
2. **SECURECARE HMO/SECURECHOICE PPO:** Bill The Health Plan directly for all charges. We are the Medicare carrier for Part A and Part B services.
3. **MEDICARE SUPPLEMENT:** Bill Medicare first and then bill The Health Plan for any co-insurance or deductibles (see Medicare crossover notice).

Medicare Crossover Notice

Effective as of Dates-of-Service 8/29/2016

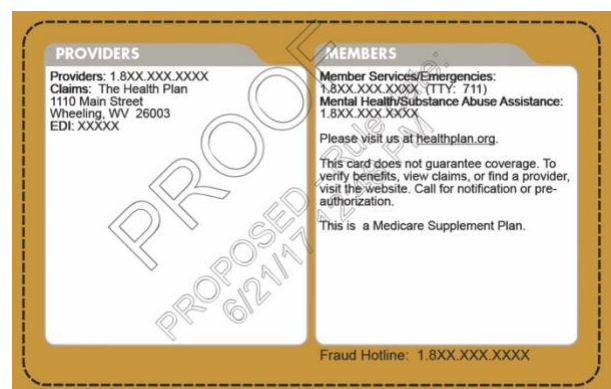
For Medicare Supplement Plans ONLY

- When your patient presents this ID card from The Health Plan, you will no longer have to submit a claim to The Health Plan after Medicare pays.
- Medicare will send us your claim information and we will then process for the remaining copayment, co-insurance, or deductible.
- As a reminder, this plan will only cover those services that have been allowed or paid by Medicare. If Medicare denies the service, The Health Plan will also deny your claim.

FRONT



BACK



If The Health Plan decides to do Medicare crossover claims for other lines of business, we will notify you at that time.



Medicare Primary Payment Example

The Health Plan Employer Group Coverage Secondary

| | |
|-----------------------|--------|
| BILLED AMOUNT | 140.00 |
| MEDICARE ALLOWABLE | 81.90 |
| MEDICARE PAYMENT | 65.52 |
| MEDICARE CO-INSURANCE | 16.38 |
| HEALTH PLAN PAYMENT | 16.38 |

THE ABOVE ARE EXAMPLES AS THEY WILL APPEAR ON YOUR PAYMENT VOUCHER

Medicare Primary Payment as Displayed on Voucher

| CPT | BILLED | ALLOWED | DISALLOWED | COPAY | COINS | COB AMT | PAID | REF W/H | NON Ref W/H | ADJ CD |
|-------|---|---------|------------|-------|-------|------------|-------|------------|-------------------|-----------|
| 99205 | 140.00 | 81.90 | .00 | .00 | .00 | 65.52 | 16.38 | .00 | .00 | .00 |
| | (Reduced to Medicare's Allowable) | | | | | | | | | |

Section 15

Payment and Voucher Claims





Payment Voucher Introduction

A [sample payment voucher](#) is included in this section with the key areas indicated by red numbers. Descriptions of the numbered areas are on the last page of the sample voucher to assist you with reading your payment voucher. The payment voucher contains three sections:

- Claims paid by line of business
- Claims denied by line of business
- Claims in process

Claims in Process

Claims received by The Health Plan that have not been adjudicated will be listed under the “claims in process” heading of your payment voucher. The Health Plan recommends that providers check their aging reports at 45 days against The Health Plan’s most recent “claims in process” report. This will enable you to track all claims submitted to The Health Plan.

If you have an outstanding claim on your aging report that does not appear on your most recent “claims in process,” you should contact The Health Plan’s Customer Service Department at 1.800.624.6961 to verify the status of the claim.

IT IS THE RESPONSIBILITY OF THE INDIVIDUAL PROVIDER TO REVIEW THE VOUCHERS TO ENSURE ALL CLAIMS ARE RECEIVED.

Resubmission of Claims Denied for Documentation

The following procedures have been implemented in order to expedite the processing of claims that are denied for additional documentation when the diagnosis does not support the level of service for Medicare, Commercial and Self-funded lines of business.

Initially, the claim will be reviewed and if it is determined that the diagnosis does not support the level of service, the claim will be denied with the more descriptive denial codes. If the provider agrees with the denial he/she may resubmit the claim with the appropriate level of service. If the provider disagrees with the denial he/she may submit appropriate documentation such as office notes, progress notes, etc. to support the level of service originally billed. The provider has **180 days from the claim payment/denial date or 180 days from the date of service to correct and resubmit the claim or supply additional documentation to support the level of service billed.**

Level I:

Once The Health Plan receives the additional documentation to support the level of service, it will be sent to the Claims Department for review by a claims reviewer other than the original claims reviewer. If the documentation supports the level of service, the claim will be reprocessed and, depending on the review date, will show on your next voucher as paid. If the documentation does not support the level of service, the claim will continue to deny. At this time, the provider may correct the claim with the appropriate level of service.

**Level II:**

If the provider feels that the level of service is appropriate, he/she may submit a written request for a third review with additional documentation and it will be sent to a medical director for review. The claim will be paid or denied upon completion of the medical director review. If the medical director agrees with the initial adjudication of the claim, the claim will deny.

Please send medical director review requests to:

The Health Plan
1110 Main Street
Wheeling, WV 26003

Level III:

If the provider does not agree with the medical director's decision, he/she may submit a written request for an outside independent review of the claim with the appropriate documentation to support the level of service. Send independent review requests to:

The Health Plan
1110 Main Street
Wheeling, WV 26003

The results of this review reflecting the medical director's determination will be sent back within 30 days from the date of the payment voucher.

Once the decision has been received from the independent reviewer, the practitioner/provider will receive written notice of their decision. If it is determined that the documentation supports the claim as submitted the claim will be reprocessed at the level of service billed. If the reviewer determines that the documentation does NOT support the claim as submitted, the provider may resubmit the claim with the appropriate level of service.

If the independent outside reviewer agrees with The Health Plan's adjudication of the claim, the provider will be responsible for the charges of the independent reviewer, which may vary depending on the hourly rate and the number of claims reviewed. An invoice will be sent to the provider along with the outside reviewer's decision.

If the independent reviewer rules in favor of the provider, the charges for the review will be the responsibility of The Health Plan. **The decision of the independent reviewer is final**, and the provider will have **30 days from the date of the determination letter to resubmit a corrected claim.**

Mountain Health Trust (MHT) Claims Have One Level of Reconsideration/Appeal

If a provider does not agree with the decision made by The Health Plan, they have the right to file a reconsideration. Providers are limited to one level of reconsideration/appeal for Mountain Health Trust (MHT) members. MHT members include WV Medicaid, WV Health Bridge, Supplemental Security Income, and WV Children's Health Insurance Program. A provider has 180 days from The Health Plan's denial date or 180 days from the date of service to request a reconsideration.



Process to Resubmit a Denied Claim

THP prefers that providers resubmit claims electronically; however, resubmission of a paper claim is acceptable.

Paper claims must be original (red ink) CMS 1500 or UB04 claim forms and include the following:

- Box 22 on the HCFA 1500 professional claim form must contain one of the following codes:
 - 7 – Replacement of prior claim
 - 8 – Void/cancel prior claim
- Use Bill Type 117 on the UB04 facility claim form to represent a hospital inpatient replacement or corrected claim
- Attach a copy of the payment voucher with the member circled or underlined (The Health Plan's optical character reader will black out any highlighted text)
- 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

Handwritten claims, copies made from an original claim form, faxed or scanned claims (black ink) will result in a rejected claim.

As an alternative to paper claims providers may submit claims electronically, free of charge, via The Health Plan's [provider portal](#). Contact your practice management consultant to learn how to utilize the portal. You may access contact information for practice management consultants on healthplan.org under "For Providers," "Overview."

To resubmit a claim electronically through a clearinghouse:

- Use reason code "7" in claim information 2300 Loop Segment CLM05 to indicate replacement of a prior claim
- If you wish to void/cancel a claim, use "8" as the reason code 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 denying as a duplicate.

If you have questions, please contact Customer Service at 1.800.624.6961 for assistance on why a claim denied and how to resubmit your claim.

Claim Resubmission Form

The Claim Resubmission Form is available [here](#).



Overpayments and Offsetting

The provider or The Health Plan can identify an overpayment. If the provider identifies the overpayment, they can submit a refund check with an explanation of the refund and/or explanation of benefits to either The Health Plan or they can call 1.800.624.6961 and request to speak with the Funds Recovery Department to approve a recoupment from any future payments to the provider.

If The Health Plan identifies an overpayment, notification will be sent to the provider of any overpayments or other payments owed within 365 days of the date of the claim payment or within the timeframe as noted in your provider agreement. You will have forty (40) days to notify us of your intent to pay or appeal the overpayment determination. If you have not refunded us within forty (40) days, we will offset the recovery amounts identified in the initial notification against your next payment voucher, or in accordance with the terms of your provider agreement, unless an appeal or refund is received. Resolution of appeals and collection of overpayments subject to appeal are conducted in accordance with your provider agreement or applicable state law. Refer to [Section 17](#) Special Investigations Unit in this manual for information on provider self-audits and overpayments.

Overpayment mailing address:

The Health Plan
Attn: Funds Recovery Department
1110 Main Street
Wheeling, WV 26003

For Mountain Health Trust (including WV Medicaid, WV Health Bridge, Supplemental Security Income and WV Children's Health Insurance Program) identified overpayments, please refer to [Section 5](#) of this Manual.

The Health Plan will comply with Ohio, West Virginia, and Medicare prompt pay requirements. Contact The Health Plan at 1.888.816.3096 for self-funded claim and appeal information. Self-funded lines of business default to individual group policy requirements regarding timely filing.

Credit Balance Explanation

When a claim is credited against your account, the credit amount can carry over more than one payment. Accordingly, it may be necessary to hold multiple vouchers and post them all at once. In order to assist your accounts receivable representative, here are the basic steps to follow in order to balance out to your deposit when credits have been applied over more than one voucher process.

- You will need to make sure to **evaluate every voucher you receive**, even those that are not accompanied by a check or electronic deposit. Vouchers with zero payments often include denials that need to be worked as well as credits applied to current and future paid claims. In the event that a credit balance appears on the voucher you will want to hold the voucher in order to reference the credit activity until the credit has cleared (i.e., until your next voucher with a positive payment amount. This excludes any voucher that **only** show "Claims in Process," no payments or credits).
- In the meantime, please be sure to resubmit corrected claims for all claims denied because the information submitted on the original claim was incorrect. This will avoid a timely filing denial and ensure those claims are promptly reprocessed for payment upon correction.



- Once the credit has been satisfied and you receive a voucher with a check or an electronic deposit, you can post all of the debits and credits that you have been holding, along with the voucher indicating that you received a check or deposit. After all debits and credits have been posted, you will balance out to the check or deposit.

Example: (see sample vouchers [here](#))

| Sample Voucher Date | Activity Description | Activity Amount | Balance | Payment Amount | |
|---------------------|----------------------|-----------------|------------|----------------|--------------|
| 10/29/2014 | Credit received | (\$319.03) | (\$319.03) | | |
| 10/29/2014 | Payment applied | 132.66 | (186.37) | \$0.00 | HOLD Voucher |
| 11/5/2014 | Payment applied | 34.90 | (151.47) | \$0.00 | HOLD Voucher |
| 11/12/2014 | Payment applied | 0.00 | (151.47) | \$0.00 | HOLD Voucher |
| 11/19/2014 | Payment applied | 67.97 | (83.50) | \$0.00 | HOLD Voucher |
| 12/17/2014 | Payment applied | 102.27 | 18.77 | | |
| 12/17/2014 | Payment applied | 167.49 | 186.26 | | |
| 12/17/2014 | Payment applied | 102.27 | 288.53 | | |
| 12/17/2014 | Payment applied | 68.28 | 356.81 | \$356.81 | |

As you can see, if you post all the debits and credits together, you will balance to your check or electronic deposit.

Section 16

Credentialing





Credentialing

The Health Plan is accredited by the National Committee on Quality Assurance (NCQA) and as such is required to comply with quality assurance standards on credentialing. In addition, The Health Plan is required to comply with the states of West Virginia and Ohio, West Virginia Mountain Health Trust (MHT) and CMS credentialing guidelines, as well as other state and regulatory requirements. Practitioners/providers who wish to provide services to MHT members will need to enroll with Medicaid Management Information System (MMIS), the state of West Virginia's fiscal agent.

The initial credentialing process includes:

- An office site survey of primary care physicians who provide service to West Virginia recipients. MHT includes WV Medicaid, WV Health Bridge, Supplemental Security Income (SSI) and WV Children's Health Insurance Program (WVCHIP).
- In addition to primary care physicians, an office site survey will be performed on obstetrics (OB)/gynecologists (GYN), durable medical equipment (DME) providers, and designated high-volume/high impact specialists who provide service to West Virginia MHT recipients
- Medical record review
- Physician application

Copies of:

- Licensure(s)
- Clinical privileges
- DEA registration
- Complete malpractice history
- Board certifications

Upon expiration of any of the above listed credentials, the credentialing department may request copies of the above expired credentials. **It is imperative that we receive this information as quickly as possible.**

The practitioner has the right to review all information submitted to The Health Plan in support of the credentialing/recredentialing application.

If you wish to review the information submitted to The Health Plan, in support of the credentialing/recredentialing application, please call the Manager of Provider Information Management at 1.740.699.6129 to schedule an appointment to come to The Health Plan. You will have access to your credentialing application and primary source verification documents received during the most current credentialing/recredentialing cycle. You will not have access to protected peer review information, references or recommendations.



Recredentialing

The Health Plan recredentials all practitioners, at a minimum within 36 months of the initial credential date.

This recredentialing process includes primary verification of:

- Licensure(s)
- Clinical privileges
- Valid DEA
- Board certification
- Adequate malpractice insurance
- Professional liability claims history
- Reappointment application
- Member complaints and quality of care issues
- Verifying the information contained on the reappointment application



Practitioner's Credentialing/Recredentialing Rights

The practitioner has the right to correct erroneous information. Any omissions, inconsistencies or erroneous information that is discovered during any of the listed verification processes will require further investigation by the Manager of Provider Information Management. The Manager of Provider Information Management services will review the information to determine if it needs to go to the medical director for direction or select a course of action that may include:

- The Manager of Provider Information Management will send a written notice to the practitioner along with a copy of the application containing the discrepancy. The letter will state that the provider has 15 calendar days to respond in writing to the request for correction/update. If there is no written response received within the 15-calendar day timespan, a credentialing representative will contact the office via email or phone to ascertain why there has been no response. Once contacted, the practitioner is afforded an additional 15 calendar days to reply. The written explanation must be returned by secure fax at 740.695.7883 or via postal mail to the Manager of Provider Information Management, or the credentialing representative listed on the letter, to 1110 Main Street, Wheeling WV, 26003.

If no response is received by the credentialing representative within 15 days of contact, the file will be placed in an inactive file and the practitioner will be notified of this status by letter.

- Once the information is received, the practitioner will be notified via email, fax, or telephone by the Manager of Provider Information Management or a credentialing representative. The information will be taken to the medical director and/or blinded and taken to the credentials committee, along with the explanation from the practitioner, for the committee's acceptance, acceptance with restrictions, or rejection.

The practitioner has the right, upon request, to be informed of the status of their credentialing or recredentialing application. The information that will be afforded to the practitioner includes: the application is still in process; it is pending to the credentials committee or in review by the medical director awaiting sign-off. The practitioner may request status by contacting The Health Plan credentialing department at 1.740.699.6279 or 1.800.624.6961, ext. 6279 or via e-mail at credentialing@healthplan.org. The practitioner will be contacted by telephone or mail with the response to his/her request for application status. This response will be within five business days of the request.

The practitioner has the right to review all information submitted to The Health Plan in support of the credentialing/recredentialing application.

If you wish to review the information submitted to The Health Plan, in support of the credentialing/recredentialing application, please call the Manager of Provider Information Management at 1.740.699.6129 to schedule an appointment to come to The Health Plan. You will have access to your credentialing application and primary source verification documents received during the most current credentialing/recredentialing cycle. You will not have access to protected peer review information, references or recommendations.



WV practitioners: The State of West Virginia mandatory [credentialing and recredentialing applications](#) are located on the West Virginia Insurance Commissioner's website. They may also be found on The Council for Affordable Quality Healthcare's (CAQH) [website](#) if you are a member of CAQH.

OH practitioners: The Health Care Simplification Act HB125 (ORC 3963.05) requires all Ohio physicians to complete the CAQH form. The Health Plan subscribes to CAQH; therefore, can retrieve the practitioner's application from the CAQH website. If the practitioner has not yet completed their initial application through CAQH, they may access the [application](#) electronically through CAQH.

OH ancillary providers: [Ancillary applications](#) are located on the Ohio Department of Insurance's website. If the practitioner is unable to obtain these forms electronically, please contact the Provider Credentialing Team at 1.800.624.6961 and these forms will be sent to you via secure fax, email, or certified mail.

Office Orientation and Medical Site Survey Form

The Office Orientation and Medical Site Survey Form is available [here](#).

Office Orientation and Behavioral Health Site Survey Form

The Office Orientation and Behavioral Health Site Survey Form is available [here](#).



Standards for Participation

To become a THP provider, a physician must meet the standards of participation as developed by The Health Plan. Practitioners cannot provide medical care to our members until they are fully credentialed.

A physician must have the following credentials:

- Drug Enforcement Administration (DEA) registration number if the scope of practice would warrant the physician to have a DEA
- Professional liability – minimum amount of \$1 million, any amount below minimum will be reviewed by the Credentials Committee
- Admitting privileges at a participating hospital
- Clear report from the National Practitioner Data Bank
- Board-certified or board eligible. If not board-certified or board-eligible, the physician must demonstrate appropriate training for specialty listed
- Signed and dated agreement
- Office site survey for primary care physicians (PCP), OB/GYN, DME providers, and those providers designated by the plan as a high-volume specialist who provides service to WV Mountain Health Trust recipients.
- Proof of current medical license(s)
- Sufficient information concerning any malpractice actions.
- NPI number and UPIN or PTAN number
 - The Centers for Medicare and Medicaid (CMS) has made it their goal to increase the accuracy of provider directories and is requesting that providers review their demographic information in the National Plan and Provider Enumeration System (NPPES) registry and make necessary corrections to the data and then attest to the accuracy of the data.
- Completed application

Practitioners/providers eligible for participation with The Health Plan are:

- Medical doctor
- Doctor of osteopathy
- Doctor of podiatric medicine
- Doctor of dental surgery
- Doctor of chiropractic medicine
- Audiologist
- Certified nurse practitioner – must submit a copy of their collaborative agreement and/or prescriptive authority (if applicable) with a physician who is a participating practitioner with The Health Plan
- Certified nurse midwife – must have a collaborative agreement with an obstetrician
- Physician assistant – the collaborating physician must be participating with The Health Plan and the PA must submit a copy of the practice agreement with the collaborating physician
- Independent physical therapist
- Optometrist
- Fully licensed psychologist
- Clinical licensed master social worker



- Ambulance provider
- Durable medical equipment – must be accredited and possess a surety bond; if applicable
- Independent speech language pathologist
- Registered dietitian, diabetic educator and nutritionist
- Counselor therapists
- Doctor of medicine in dentistry

Provider/facilities eligible for affiliation in The Health Plan network are:

- Ambulatory surgical centers – must be accredited
- End-stage renal disease facilities
- Federally qualified health centers
- Rural health clinics
- Home health care facilities
- Infusion therapy providers – must be accredited
- Hospitals – must be accredited
- Critical access hospitals
- Long-term acute care hospitals
- Outpatient physical therapy facilities
- Skilled nursing facilities
- Accredited behavioral health facilities

Providers and facilities must meet certain requirements to be a participating provider with The Health Plan. Please contact our contracting department for specific requirements by calling 1.800.624.6961.

The agreement will not be executed on behalf of The Health Plan until the credentialing process has been completed and the practitioner has been approved for participation. Practitioner cannot see members of The Health Plan until they are fully credentialed with the plan.

Notification of acceptance and/or rejection will be sent, in written form, within 60 days of the decision.

The Health Plan will complete the credentialing process within 90 days of receipt of the application or 180 days from the date of signature on the attestation statement of the application.

In addition to the above credentials, The Health Plan quality improvement committee has identified the following behaviors and expectations for The Health Plan physicians, who should:

- Have 24-hour availability, seven days a week, with backup coverage
- Accept members of any or all THP products, as required by The Health Plan
- Admit THP patients to participating hospitals
- Accept and support The Health Plan policies
- Allow medical records and office to be reviewed as part of a collaborative quality program
- Have records and office meet criteria established by The Health Plan and participating physician
- May not discriminate against The Health Plan patients or “de-market” The Health Plan
- Admit under own service to participating hospitals if patient's condition is within physician's range of expertise and scope of privileges
- Meet the CME requirement that is required for state licensure

**The following guidelines are for PCPs only:**

A PCP shall be required to provide a minimum of 20 hours per week of patient care availability in a county to be considered as a PCP in that county. The only exception shall be practitioners who provide services at multiple sites.

In the instance of multiple sites, these shall be acceptable providing the alternate location is within 30 miles or 60 minutes driving time of the primary location and the alternate location meets all the necessary requirements, as determined appropriate by the credentials committee and/or the quality improvement committee. The PCP must also provide coverage 24 hours a day, seven days per week and have privileges at a provider facility or have arranged with a contracting provider/hospitalist group to handle all inpatient care for his/her patients.

The PCP maintains at least 50% primary care practice.

The following guidelines are for specialty providers (specialists and secondary care physicians):

Specialist practitioners who provide patient care access fewer than 20 hours per week in a THP county shall be considered as a practitioner in that region only if the specialty service of the physician is not otherwise available through sufficient plan practitioners residing in that region. Furthermore, the ability of the specialist to provide the necessary service locally including inpatient care, surgery and backup support shall be considered by the credentials committee and/or quality improvement committee in making the determination of the acceptance of the practitioner as a plan provider.

The committee shall consider the specific needs of the specialty and how the physician will accommodate his/her patient needs. Practitioners who provide only limited services locally shall not be permitted to be accepted as a plan provider. In addition, if it is determined that the physician specialty requires the physician to be available locally, the practitioner shall not be accepted as a plan provider.

Practitioners Credentialing Rights

The practitioner has the right, upon request, to review information in support of his/her credentialing/recredentialing application by contacting The Health Plan credentialing department at 1.740.699.6279 or 1.800.624.6961, ext. 6279. The review will be at The Health Plan office and limited to the results of the primary verification of credentials. References, recommendations or other peer review protected information will not be shared with the practitioner.

The practitioner has the right to correct erroneous information. Any omissions, inconsistencies or erroneous information that is discovered during any of the listed verification processes will require further investigation by the Manager of Provider Information Management. The Manager of Provider Information Management will review the information to determine if it needs to go to the medical director for direction or select a course of action that may include:

- The Manager of Provider Information Management will send a written notice to the practitioner along with a copy of the application containing the discrepancy. The letter will state that the provider has 15 calendar days to respond in writing to the request for correction/update. If there is no written response received within the 15-calendar day timespan, a credentialing representative will contact the office via email or phone to ascertain why there has been no response. Once contacted, the practitioner is afforded an additional 15 calendar days to reply. The written explanation must be returned by secure fax at 740.695.7883 or via postal mail to the Manager of



Provider Information Management , or the credentialing representative listed on the letter, to 1110 Main Street, Wheeling WV, 26003.

If no response is received within 15 days of contact by the credentialing representative, the file will be placed in an inactive file and the practitioner will be notified of this status by letter.

- Once the information is received, the practitioner will be notified via email, fax, or telephone by the manager or a credentialing representative. The information will be taken to the medical director and/or blinded and taken to the credentials committee, along with the explanation from the practitioner, for the committee's acceptance, acceptance with restrictions, or rejection.

The practitioner has the right, upon request, to be informed of the status of their credentialing or recredentialing application. The information that will be afforded to the practitioner includes if the application is still in process, it is pending to the credentials committee or in review by the medical director awaiting sign-off. The practitioner may request status by contacting The Health Plan credentialing department at 1.740.699.6279 or 1.800.624.6961, ext. 6279 or via email at credentialing@healthplan.org. The practitioner will be contacted by telephone or mail with the response to his/her request for application status. This response will be within 5 business days of the request.

Initial Certification

During the credentialing procedure, information that the physician submits to The Health Plan as part of the application process is verified. This information includes, but is not limited to, medical licensure and board certification, plus the credentials listed in a previous section. In addition, each primary care physician, OB/GYN, DME provider, and designated high-volume specialist who provide medical service to WV Mountain Health Trust recipients must take part in an office site survey at the initial credentialing process, unless the practitioner has joined an existing group and that office has previously completed a site survey. Applicants and their practices are reviewed using certification standards developed by The Health Plan and approved by The Health Plan's physician committee.



The Health Plan Standards for Patient Records

The medical record should be organized with the various types of information placed in a consistent location to enable easy access for reviewing the chart. **Practitioners are responsible for medical records that were created in their office only.**

1. Patient Identification

Each page in the record or electronic file contains the patient's name and date of birth or chart ID.

2. Advance Directives

There is evidence that advance directives have been executed or that information regarding advance directives was provided to The Health Plan members age 18 and over.

3. Completed Problem List

A problem list noting significant and/or chronic medical/surgical conditions is in the medical record.

4. Completed Medication List

Medication list includes name of medication, dosage, frequency, start date and stop date. The medication list should be reconciled at each visit. Any change to medications requires either dating and initialing the change or entering a stop date for the initial entry and re-entering the medication with the change. For patients that have had admissions to an acute or non-acute facility, the medication reconciliation should include documentation indicating current medications and discharge medications were reconciled.

5. Allergies and Adverse Reactions

Medication/food allergies and adverse reactions are prominently noted in the record. Absence of allergies should be recorded as NKA. The documentation for allergies should be in a consistent location in all charts.

6. Provider Identification

All entries in the medical record should contain the author's signature and credentials. If the provider utilizes EHR system, electronic signatures and credentials are acceptable. Initials may be used only if there is a signature log identifying first initial, last name, and credentials. This standard excludes ancillary documents such as problem list, medication list, flow sheets e.g., The Health Plan Diabetic Flow Sheet.

7. Dated Entries

All entries are dated.

8. Legibility

The record is legible to someone other than the writer. Any record judged illegible by one physician reviewer should be evaluated by a second reviewer. A second reviewer can be office staff. Non-compliance occurs when a second reviewer cannot read the entry.

9. Diagnostic Information

Records to help support the documented diagnosis.

10. Vital Signs: Blood Pressure

Blood pressure measurements should be checked using an optimal technique at every visit with a primary care physician and recorded in the medical record. If the blood pressure reading is abnormally high or abnormally low based on the patient's age, gender, medical/surgical



conditions, etc., the blood pressure measurement should be repeated. Both blood pressure readings should be recorded.

11. History and Physical (H&P)

The history and physical documents contain subjective and objective information. H&Ps performed by other medical professionals participating in a member's care meets compliance. Patient-completed questionnaires count as evidence of compliance for the history component.

12. Lab/Other Studies

All lab and other studies are ordered as appropriate for member age, gender and symptoms, as well as chronic conditions per The Health Plan guidelines.

13. Plan of Action/Treatment

There must be evidence of a plan of action/treatment for presenting problem(s).

14. Return Visit/Follow-Up

Encounter forms or notes have a notation, when indicated, regarding follow-up care, calls, or visits. The specific time of return is noted in weeks, months, or PRN.

15. Problems from Previous Visits

Unresolved problems from previous office visits are addressed in subsequent visits. An unresolved problem is defined as an illness or symptoms that are not responding to treatment.

16. Pain

Documentation in the medical record must include evidence of a pain assessment and the date it was performed. This may include a result of an assessment using a standardized pain assessment tool such as a numerical rating scale or pictorial pain scales for example or documentation including negative or positive findings for pain.

Screening for chest pain alone or documentation of chest pain alone does not meet overall pain assessment.

17. Cognitive and Physical Development/Functional Assessment

Cognitive assessment is meant as an assessment of conscious intellectual activity (as thinking, reasoning, remembering, imagining, or learning words). Assessing and documenting cognitive status on an annual basis during the annual wellness visit, allows practitioners an opportunity to identify delays in mental developmental for children and monitor cognitive decline in patients over time.

Physical development and/or functional assessment is meant as an objective review to identify the milestones of normal growth, development and the signs of developmental delay for children, prevent functional decline, and improve health-related quality of life. Optimizing functional status as an outcome of care is not limited to the elderly but is of major concern for individuals of all ages with chronic illness or disability. Functional status can include such things as ambulation/mobility, sensory ability (hearing/vision/speech), taking medications, ADLs and self-care to name a few.

**18. Continuity and Coordination of Care**

If a consultation is requested, there should be a note from the consultant in the record. The record should indicate communication and feedback between the primary care physician and all specialists. Specialists that necessitate patients' having frequent visits (ex: daily, biweekly, weekly) for care and treatment purposes such as chemotherapy, physical therapy, counselor/therapists, wound care etc. do not need to provide feedback with each visit. It is expected that any positive and/or negative outcomes be relayed to the primary care provider timely.

19. Emergency Room Visits

There is evidence in the medical record of visits to emergency rooms, *when applicable*.

20. Hospital Admissions

There is evidence in the medical record of admissions to hospitals, *when applicable*.

21. Tobacco Use

For patients age 11 and over, assessment of the use of tobacco and smokeless tobacco must be documented. Counseling must occur with identification of tobacco use.

22. Alcohol Use

For patients age 11 and over, assessment of the use of alcoholic beverages must be documented. Counseling must occur with identification of alcohol use.

For patients age 21 and over, assessment of the use of alcoholic beverages must be documented. Moderate drinking is defined as no more than one drink a day for women and no more than two drinks a day for men. Twelve ounces of beer; 5 ounces of wine; or 1.5 ounces of distilled spirits (80 proof) counts as one drink. Counseling must occur if alcohol abuse is identified.

23. Substance Abuse

For patients age 11 and over, assessment of substance abuse must be documented. Counseling must occur with identification of substance abuse.

24. Preventive Services

There is evidence that preventive screening and services are offered in accordance with The Health Plan Preventive Health Guidelines.

25. Immunization Record

An immunization record for children and adults is up-to-date according to The Health Plan Preventive Health Guidelines. Practitioners not providing immunizations in their offices are responsible for obtaining updated information from the source providing the immunizations.

26. Audit Trail

The office maintains an audit log to track access to patient information including username, document(s), and description of use.



Electronic Health Record (EHR)

1. Copy/Paste or Cut/Paste

The office has a policy/procedure to monitor and audit information "copied and pasted" or "cut and pasted" into the EHR to ensure copied information includes proper validation including name, credentials, date, time, and source of data.

2. Defaults

Defaults are defined as data that is entered that does not require a positive action or selection, or data is entered by abbreviated words or keystrokes.

The office has a policy/procedure to verify the validity of auto-populated information.

3. Multiple individuals adding text/addendums to the same process note, entry, flowsheet

Documents with multiple authors or contributors retain signatures so that each individual's contribution is clearly identified.

4. E-prescribing

For offices currently utilizing E-prescribing, they have a policy/procedure for monitoring to prevent fraud, waste, and abuse.

5. Technical Specifications

The office has a policy/procedure such as a backup system to prevent loss or destruction of EHR.

6. EHR Health Information Exchange

The office has a policy/procedure to ensure secure, authorized electronic exchange of patient information.

Resources used in standard development:

- The Bureau for Medical Services (BMS)
- Centers for Disease Control
- The Centers for Medicare and Medicaid (CMS) Quality Improvement Standards
- Qlarant (formerly Delmarva) Quality Improvement Standards
- The Health Plan Guidelines
- The Health Plan Quality Improvement Committee
- US Department of Health and Human Services



Medical Records and Confidentiality Statement

The medical records and confidentiality statement ensure that a separate comprehensive medical record is created and maintained in a confidential manner for each member, as well as provides easy access to all biographical and medical information and promotes quality care.

All participating physicians and providers shall maintain a separate onsite and up-to-date member medical record in accordance with The Health Plan standards for patient records. Providers shall comply with all federal and state laws and regulations which are consistent with good medical and professional practice.

All physicians shall preserve all records related to members for a period of not less than 10 years and retain records longer if the records are under review or audit.

The medical records shall be made available, as needed, to each physician treating the member. These records will be made available upon request of an authorized representative of The Health Plan for medical audit, utilization review, fiscal audit, and other periodic monitoring.

All medical records and discussion of details regarding patient information should only take place to complete normal job duties. Such discussion outside of regular working duties and home is strictly prohibited.

Members shall have the opportunity to approve or deny the release of identifiable personal health information by the physician or the provider except when the release is required by law. Member information shall not be released without signed authorization.

Copying member medical records and other data containing patient health information should be kept to the minimum that is needed to accomplish the required job. Member information, whether personal or medical, shall be released only when necessary.

All member's medical record information should be kept confidential.

- All files should have limited access and not left open where they could be casually read.
- Computer system files require special password capability for access. All computer terminals accessing the mainframe should be logged off at the close of each day to prevent unauthorized access to system data.

All member medical records requiring disposal should be placed in appropriate receptacles for shredding. Burning may be used in lieu of shredding.

All physicians should require the review of this policy with any new employee, and with all employees on an annual basis.



Signature Log Form

Physician offices should sign all entries in patients' charts either by a signature or initials (full name and title). When initials are used, a record of the initials, along with the person's name, should be kept on file in each office.

For your convenience, we have devised a signature log for your use and is available [here](#). The form contains the following sections:

- **Legible name** — print the employee's name
- **Credentials** — MD, DO, DPM, DDS, CNP, NP, PA, etc.
- **Legal signature with credentials** — have the employee sign their name with credentials
- **Any signature variations** — employee signature if different from their legal signature

The signature log form may be reproduced.

Onsite visits of physician offices will be conducted spontaneously to review charts, office procedures, hazardous waste disposal and pharmaceutical and narcotic storage.

The provider servicing department attempts to educate offices regarding these areas as we receive additional information. It is the office's responsibility to implement these procedures.

The contact information for the practice management consultant assigned to your county can be located on the website under "For Providers," "Meet the Provider Engagement Team."

Telephone Message Form

At the request of many offices, we have devised a telephone message form for your use. This form contains the necessary information needed to document phone calls received from patients. It provides space for recording times and intervention that may be important. By using this form, you may reduce the number of messages contained in your charts.

In today's legal climate, it is increasingly important to document information accurately and in a comprehensive manner. One office had indicated that a form such as this afforded them the protection and documentation necessary to defend their office against a liability claim.

Use of this form is recommended but not mandatory. The form is available [here](#).

Section 17

Compliance, SIU
and FWA





Fraud, Waste and Abuse Regulations and Guidelines

Fraud, Waste and Abuse (FWA) Policies and Related Laws

The Health Plan's fraud, waste, and abuse policies were established to prevent, detect, and correct fraudulent, wasteful, or abusive practices perpetrated by employees, members, providers and facilities, including providers and facilities not contracted with The Health Plan. Compliance with these policies is the responsibility of every employee and anyone providing services to members of The Health Plan. Providers should ensure that ALL staff are thoroughly educated on state and federal requirements and that appropriate compliance programs are in place. The Health Plan expects its first tier, downstream, and related entities (FDRs), its WV Medicaid and WV Children's Health Insurance Program (CHIP) Subcontractors, and its providers to operate in accordance with all applicable federal and state laws, regulations, and Medicare and Mountain Health Trust (MHT) (including WV Medicaid, WV Health Bridge, Supplemental Security Income [SSI] and WV CHIP) program requirements including, but not limited to the following:

1. Health Care Fraud (18 U.S.C. §1347)

The Health Care Fraud statute makes it a crime for anyone to knowingly and willfully execute or attempt to execute a scheme to defraud any health care benefit program or to obtain by false or fraudulent pretenses, representations, or promises any of the money or property from a health care benefit program in connection with the delivery of or payment for health care benefits.

2. Federal and State False Claims Acts (31 U.S.C. §§ 3729-3733)

The Federal False Claims Act (FCA) prohibits any person from engaging in any of the following activities:

- a. Knowingly submitting a false or fraudulent claim for payment to the United States government;
- b. Knowingly making a false record or statement in order to get a false or fraudulent claim paid or approved by the government;
- c. Conspiring to defraud the government in order to get a false or fraudulent claim paid or approved by the government; or
- d. Knowingly making a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the government.

3. Federal Criminal False Claims Statutes (18 U.S.C. §§287,1001)

Federal law makes it a criminal offense for anyone to make a claim to the United States government knowing that it is false, fictitious, or fraudulent. This offense carries a criminal penalty of up to five years in prison and a monetary fine.

4. Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b))

This statute prohibits anyone from knowingly and willfully receiving or paying anything of value to influence the referral of federal health care program business, including Medicare and MHT. Kickbacks can take many forms such as cash payments, entertainment, credits, gifts, free goods or services, the forgiveness of debt, or the sale or purchase of items at a price that is inconsistent with fair market value. Kickbacks may also include the routine waiver of copayments and/or co-insurance. Penalties for anti-kickback violations include fines of up to \$25,000, imprisonment for up to five years, civil money penalties up to \$50,000, and exclusion from participation in federal health care programs.



5. The Beneficiary Inducement Statute (42 U.S.C. § 1320a-7a(a)(5))

This statute makes it illegal to offer remuneration that a person knows, or should know, is likely to influence a beneficiary to select a particular provider, practitioner, or supplier, including a retail, mail order or specialty pharmacy.

6. Physician Self-Referral (“Stark”) Statute (42 U.S.C. § 1395nn)

The Stark Law prohibits a physician from referring Medicare patients for designated health services to an entity with which the physician (or an immediate family member) has a financial relationship, unless an exception applies. Stark Law also prohibits the designated health services entity from submitting claims to Medicare for services resulting from a prohibited referral. Penalties for Stark Law violations include overpayment/refund obligations, FCA liability, and civil monetary penalties. Stark Law is a “strict liability” statute and does not require proof of intent.

7. Fraud Enforcement and Recovery Act (FERA) of 2009

FERA made significant changes to the False Claims Act (FCA). FERA makes it clear that the FCA imposes liability for the improper retention of a Medicare overpayment. Consequently, a health care provider may now violate the FCA if it conceals, improperly avoids, or decreases an “obligation” to pay money to the government.

FWA Training and Education

All health care practitioners/providers or staff who render health care services to Medicare Advantage enrollees, provide Medicare Part C services, administer the Medicare Part D prescription drug benefit, or provide services to MHT recipients should complete FWA training. FWA training may be completed through the practitioners’/providers’ own internal compliance program or using The Health Plan Compliance and FWA training slides available on The Health Plan website. FWA training should be completed upon hire (within 90 days) and annually thereafter.

Practitioners/providers must maintain records of their completion of FWA training, as well as their employees’ training, for a period of at least ten years.

Reporting

The Health Plan Special Investigations Unit (SIU) and Compliance Department actively review all reports of suspected FWA and non-compliance. To report suspected fraud, waste or abuse and/or suspected issues of non-compliance, call the hotline at 1.877.296.7283. The Health Plan maintains a non-retaliation policy for anyone reporting issues in good faith; everyone should feel confident that NO adverse actions can or will be taken for reporting issues of concern. All issues may be reported anonymously.

A number of resources, including training slides are available on The Health Plan provider portal under “Resource Library,” “Compliance.”



Special Investigations Unit

MHT 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, honoring the commitment to The Health Plan's network and its members, and ensuring compliance with federal regulations.

The Special Investigations Unit (SIU) plays a vital role in detecting, preventing, and correcting fraud, waste, and abuse, in ensuring payment integrity, and in recovering overpayments as required by state and federal regulations. SIU activities may include, but are not limited to, data mining, pre- and post-payment reviews, site visits, audits, and the facilitation of provider self-audits. In the event fraud or abuse 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. Providers may be contacted by the SIU as a result of routine post-payment monitoring, or in response to a specific concern. Providers are expected to cooperate with the SIU and must comply promptly with requests for records or other information to ensure timely completion of audits and reviews.

Provider Self-Audits

All parties have an obligation to ensure that submitted claims are billed and paid properly. Federal and state regulations require managed care organizations that serve the MHT and Medicare populations to have procedures in place designed to detect and prevent fraud, waste, and abuse.

The Health Plan is committed to ensuring payment integrity across all lines of business. In furtherance of this objective, the Special Investigations Unit (SIU) may review paid claims either as part of a proactive payment integrity program, or in response to specific allegations. One tool the SIU incorporates into its payment integrity processes is the provider self-audit.

A provider self-audit is an audit, examination, or review performed by and within a provider's business. A self-audit may be performed proactively by a provider as part of their own efforts to ensure payment integrity or at the direction of The Health Plan based on the discovery of questionable billing patterns. Self-audits are often preferred by providers because they are reviewing their own records, versus having SIU staff and/or government regulators on-site conducting an in-depth review. Additionally, a self-audit process is generally educational for the provider and their billing staff, resulting in a greater likelihood of future compliance.

Self-audits will be narrowly focused while still sufficient to address the relevant issues and will be limited in scope and duration. Self-audits may be utilized for cases meeting the following criteria:

1. Clear indications that an overpayment has occurred,
2. The overpayment is likely to be expansive,
3. No previous or immediate indicators of intent to defraud, and
4. High likelihood that the issue(s) can be resolved without significant SIU intervention.



Providers will be notified in writing when a self-audit is required. Self-audits will be designed on a case-by-case basis, depending on the specific circumstances giving rise to the audit. However, in all instances a self-audit notification will include the purpose of the review, the universe of claims and how that universe was determined, a deadline for completion, and instructions on how to remit any overpayments. Overpayments made under any federal health insurance program must be recovered. Refer to **Section 15** "Payment Voucher and Claims, Overpayments and Offsetting" in this manual for timelines and processes related to overpayment recoveries.

The self-audit results will be reviewed by The Health Plan. The SIU may review documentation to validate the results and/or may meet with the provider or their staff to discuss any questionable items or further concerns. The provider should maintain copies of self-audit information and documentation for future reference. The provider will be notified in writing upon conclusion of the self-audit review.

Acceptance of a provider self-audit or subsequent repayment does not necessarily constitute agreement with the audit results or the overpayment amount, if it is later discovered that the self-audit results contained material misrepresentations or that supporting documentation or other relevant information was altered.

Compliance Through Training

The Health Plan uses education as a tool to ensure our members receive the highest quality of care by you, the provider. We achieve this through periodic reminders, updates and by communicating various compliance topics to facilitate our preventative approach.

- 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.
- Additional compliance information can be found in the U.S. Department of Health & Human Services Office of Inspector General's *A Roadmap for New Physicians: Avoiding Medicare and Medicaid Fraud and Abuse* which can be accessed at oig.hhs.gov/compliance/physician-education/index.asp.
- Annual D-SNP training and attestation are required if you provide health care services to five or more of The Health Plan's D-SNP members in the prior quarter. Your practice management consultant will contact you to inform you of the requirement to complete training and provide you with the training materials and attestation form. Locate the contact information for the practice management consultant assigned to your county [here](#).
- You are required to maintain evidence of training for 10 years. This may be in the form of attestations, training logs or other means sufficient to document completion of these obligations.
- It is recommended that you verify with your outside billing and/or management companies that they are conducting compliance and FWA training as part of the seven core elements of an effective compliance program.

For additional information or assistance, please contact the Provider Information Management Department at providersupport@healthplan.org.



The Health Plan Resources

The Health Plan provides training materials to assist providers with required and recommended training. Please visit The Health Plan's provider portal under "Resource Library" to take advantage of the following training documents:

1. THP Medicare Advantage D-SNP Training
2. FDR-Subcontractor Standards of Conduct
3. Hotline Poster (for download in your office)
4. Code of Conduct
5. Fraud, Waste and Abuse Training
6. OIG Training Roadmap for New Physicians
7. Cultural Competency and SDoH Provider Training

Government Resources

1. Compliance Guidance for Individual and Small Group Physician Practices
oig.hhs.gov/authorities/docs/physician.pdf
2. Compliance Guidance for Medicare Choice Organizations
oig.hhs.gov/fraud/docs/complianceguidance/111599.pdf
3. Health Insurance Portability and Accountability Act (HIPAA)
hhs.gov/hipaa/for-professionals/index.html
4. Stark Law (Physician Self-Referral)
cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/index.html?redirect=/PhysicianSelfReferral/



Compliance Through Reporting

The Health Plan believes it is the duty of every person who has knowledge or a good faith belief of a potential compliance issue to promptly report the issue or concern upon discovery. This reporting obligation applies even if the individual with the information is not in a position to mitigate or resolve the problem. This obligation applies to all of The Health Plan's first tier, downstream and related entities (FDRs), MHT Subcontractors and contracted providers.

The Health Plan also believes that an issue involving potential or actual non-compliance or FWA can be best investigated and remediated if an entity feels comfortable reporting such incidents through designated channels. There are various mechanisms available to confidentially report compliance concerns or suspected FWA.

- If your organization does not maintain a confidential FWA and compliance reporting mechanism, The Health Plan provides various reporting resources: a confidential FWA and compliance hotline at 1.877.296.7283, email at compliance@healthplan.org, SIU@healthplan.org or on our website at healthplan.org. These reporting mechanisms are available and widely publicized to all employees, providers and contractors to report potential issues involving FWA and/or non-compliance.
- The Health Plan has adopted and requires all FDR, Subcontractors and provider entities to adopt and enforce a zero-tolerance policy for intimidation or retaliation against anyone who reports, in good faith, suspected or actual misconduct.

Federal law prohibits payment by Medicare, Medicaid, CHIP or any other federal health care program for an item or service furnished by a person or entity excluded from participation in these federal programs. As a Medicare Advantage organization, Part D plan sponsor and Medicaid and WV CHIP contractor, The Health Plan, its FDRs, Subcontractors and providers are prohibited from contracting with, or doing business with, any person or entity that has been excluded from participation in these federal programs. Prior to hire and/or contracting, and monthly thereafter, each FDR, Subcontractor and provider must perform a check to confirm its employees, governing body, volunteers and downstream entities that perform administrative or health care services for The Health Plan's Medicare and MHT lines of business are not excluded from participation in federally-funded health care programs according to the OIG List of Excluded Individuals and Entities and the System for Award Management (SAM) exclusion databases.

- Office of Inspector General (OIG) list of excluded individuals and entities: exclusions.oig.hhs.gov
- General Services Administration (GSA) System for Award Management (SAM): sam.gov/SAM/pages/public/searchRecords/advancedPIRSearch.jsf
- In the event any of your employees or downstream entities are found on either of these exclusion lists, you must immediately remove the individual/entity from work related directly or indirectly to The Health Plan's Medicare and MHT programs and notify The Health Plan of your findings.
- You must maintain a record of exclusion list reviews (i.e., logs or other records) to document that each employee and downstream entity has been checked through the exclusion databases in accordance with current laws, regulations and CMS requirements.





- For further information on exclusion list requirements, refer to § 1862(e)(1)(B) of the Social Security Act, 42 C.F.R. § 422.752(a)(8), 42 C.F.R. § 423.752(a)(6), 42 C.F.R. § 1001.1901, the CMS Managed Care Manual, Chapter 21, Section 50.6.8 and the CMS Prescription Drug Benefit Manual, Chapter 9, Section 50.6.8.

The Health Plan will continue to educate our providers with reminders, bulletins and updates to promote compliance, and foster a continued and long-standing relationship with all of our valued providers. Thank you for your dedication and continued hard work toward satisfying the overall health care needs of our members.

Other Resources:

1. Health Care Administrators Association (HCAA):
hcaa.org
2. Health Care Compliance Association (HCCA):
hcca-info.org
3. Society of Corporate Compliance and Ethics (SCCE):
corporatecompliance.org
4. American Health Law Association (AHLA):
healthlawyers.org
5. National Health Care Anti-Fraud Association (NHCAA):
nhcaa.org
6. Institute for Health Care Improvement (IHI):
ihi.org
7. A Roadmap for New Physicians: Avoiding Medicare and Medicaid Fraud and Abuse:
oig.hhs.gov/compliance/physician-education/index.asp



HIPAA Privacy and Security

The Health Plan is committed to ensuring the confidentiality, integrity and availability of our members' protected health information, or PHI. HIPAA privacy rules mandate that The Health Plan, our business associates and providers comply with its the privacy and security rules. An individual's PHI must be protected.

PHI includes individually identifiable information that relates to an individual's past, present or future health condition whether in written, spoken or electronic form.

HIPAA, The Health Insurance Portability and Accountability Act, is a federal law that requires The Health Plan, our contracted providers and our First Tier, Downstream and Related Entities (FDRs) to:

- Properly secure PHI (physically and electronically)
- Protect the privacy of member/patient information
- Abide by the "minimum necessary" standard for the use and disclosure of member/patient information
- Address member/patient rights for the access, use and disclosure of his or her health information

The Health Information Technology for Economic and Clinical Health (HITECH) Act and the HIPAA Final Omnibus Rule updated the original federal HIPAA privacy and security standards to include:

- Requirements for breach notification
- Member/patient rights to obtain electronic copies of their electronic health record
- Makes business associates directly liable for compliance with HIPAA provisions
- Increased fines and penalties for violations
- Civil penalties range from \$100 - \$1,500,000 per year
- Criminal penalties range from \$50,000 - \$250,000 and imprisonment of up to 10 years

Who Does HIPAA Apply To?

HIPAA laws and regulations apply to health plans, health care providers and health care clearinghouses as well as business associates who perform services on their behalf.

Safeguarding PHI

Here are some ways to protect member/patient information:

- Use PHI only when necessary as part of job duties
- Use only the minimum necessary information to perform job duties
- Double check printers, faxes and copiers when finished using them
- Never leave PHI unattended in a bag, briefcase or vehicle
- When mailing documents, verify that each page belongs to the particular patient
- Ensure that computers are locked when unattended
- Create strong passwords, and never share usernames or passwords
- Do not install unknown or unsolicited programs onto work computers
- Ensure that information on monitors/screens is not visible to patients or visitors
- Never share patient information through social media, even if it is public knowledge
- When discussing patient care, take steps to reduce the likelihood others will overhear
- Keep paper documents that contain PHI out of view from others
- Dispose of PHI properly when no longer needed.



These are just a few ways to help ensure the confidentiality of patient PHI. Truly protecting the information that is entrusted to healthcare providers requires a commonsense approach that depends upon strict adherence to established policies and procedures.

The Health Plan has implemented HIPAA related training for all of its employees, which is distributed to staff upon hire and annually thereafter. It is recommended that all entities who work with PHI establish their own privacy and security program for their individual organization, and execute an inclusive, well-rounded training regimen to keep employees informed of their responsibilities surrounding patient/member rights and protections under the law.

HIPAA information and related forms can be found on our [website](#).

Resources:

- U.S. Department of Health and Human Services- Office for Civil Rights (OCR):
hhs.gov/hipaa/for-professionals/index.html
- HIPAA Frequently Asked Questions for Professionals (FAQs):
hhs.gov/hipaa/for-professionals/faq