ProviderFocus

A Publication of The Health Plan • September 2021

Provider Manual

The Provider Practitioner Manual is updated annually in July and may be accessed on The Health Plan's public website at healthplan.org/providers/resources/provider-manual.

Inside this issue …

Lowering Lab Costs

Assisting Members

The Health Plan (THP) has developed a preferred laboratory network that launched January 1, 2020. These labs were selected based on outstanding quality, access and service.

Preferred lab network providers are available to all Commercial members of The Health Plan and THP Insurance Company (including WV PEIA members that have selected THP as their health plan carrier). The preferred labs will be listed in the provider directory.

When possible and clinically appropriate, providers are encouraged to order tests from a preferred lab. By using a preferred lab, members will maximize their healthcare benefits and save on out-of-pocket costs. THP will waive applicable deductibles and/or coinsurances associated with a member's benefit plan when a member accesses services from THP's preferred lab network. A patient's responsibility for routine testing can be as low as $0.

LabCorp was selected to be part of THP's preferred lab network. LabCorp offers a comprehensive test menu of nearly 5,000 specialty and genetic tests. Contact LabCorp directly at labcorp.com/contact-rep if you don't already have an account or pickup schedule established with them.

Commercial members continue to have access to contracted labs that are part of The Health Plan network even if they are not part of the preferred lab network. The Health Plan will not limit those routine labs that are performed within a participating doctor's office.

Feel free to contact THP's Customer Service at 1.877.847.7901 should you have any questions.

Low Income Medicare Beneficiaries

The QMB (Qualified Medicare Beneficiary) Program is a Medicaid benefit that pays Medicare premiums and cost sharing for certain low-income Medicare beneficiaries. Federal law prohibits Medicare providers from collecting Medicare Part A and Part B coinsurance, copayments and deductibles from those enrolled in the QMB Program, including those enrolled in Medicare Advantage and other Part C Plans. If you are a PCP, THP has coded your patient rosters with a symbol to help you identify which of your patients meet this income level. Patient rosters are available on our secure provider portal located at myplan.healthplan.org.

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

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

1.800.MEDICARE (1.800.633.4227).

Help Us Help Members Find You

Keep Provider/Practice Info Up-to-Date

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

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

Available Online

Clinical Practice Guidelines

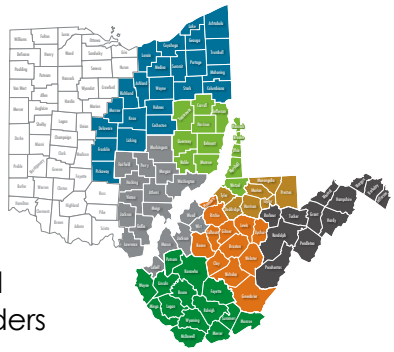
The Health Plan and participating practitioners routinely review and update the preventive health guidelines and clinical practice guidelines. These are available to providers as a reference tool to encourage and assist in planning patients' care. To make the information more accessible and convenient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

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

Provider Servicing Team

Meet the team!

In an effort to maximize positive member and provider experiences, The Health Plan has a Provider Servicing Team to serve our provider network. Each county in our network has a designated practice management consultant available to answer questions, provide education and serve as a valuable resource to our providers and their staff.



healthplan.org/providers/overview/meet-provider-servicing-team

Hours of Operation Reminder to Providers

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

REMINDER: Signatures, Credentials and Dates Are Important

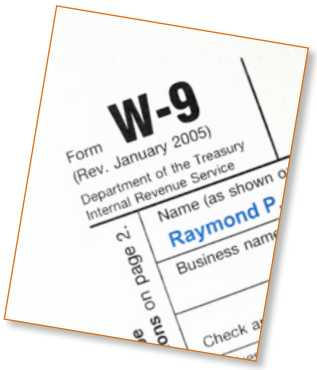
Each entry in the patient's medical record requires an acceptable signature and credentials, as defined by CMS, and the date on which the service was performed.

Member Rights and Responsibilities

We would like to remind all provider offices that the member rights and responsibilities can be found in the Provider Manual in Section 3 and Section 5_21. This manual is available on our website, healthplan.org. If you would like a copy please contact Provider Relations Customer Service at 1.800.624.6961, ext. 7901.

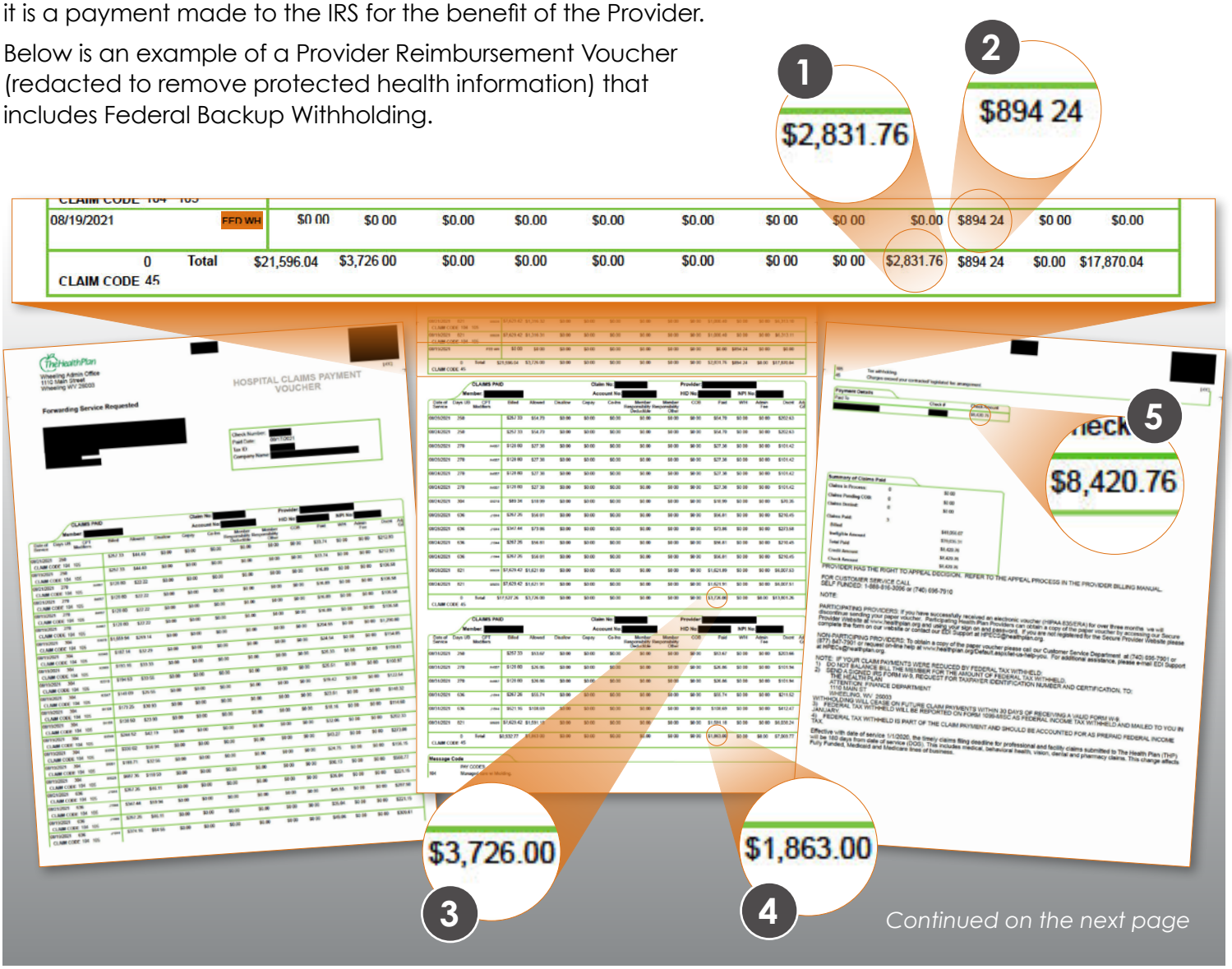
Provider Payments

Federal Backup Withholding



The Health Plan is required by the Internal Revenue Service to withhold 24% of payments made to providers or vendors who have not provided us with a valid Form W-9 Taxpayer Identification Number. Backup Withholding amounts are displayed on the Provider Reimbursement Voucher under the column heading labelled "W/H". The amount withheld from the Provider's payment for Federal backup withholding is remitted by The Health Plan to the Internal Revenue Service and will appear in Box 4, Federal Income Tax Withheld, on the Provider's Form 1099-MISC issued in January the following year. Providers can include this amount as a tax payment when filing their annual federal tax return. Providers should consider the paid amount for the claim to be the total of the cash received (via check or ACH payment) for the claim plus the amount of Federal Backup Withholding. Federal Backup Withholding should be accounted for by the Provider as prepaid federal income tax since it is a payment made to the IRS for the benefit of the Provider.

Below is an example of a Provider Reimbursement Voucher (redacted to remove protected health information) that includes Federal Backup Withholding.



The information below provides additional information regarding the total amount paid for the claim.

	Paid Directly to Provider (PAID)	Federal Backup Withheld on Provider's Payment (FES WH)	Total Claim Payment
1 Claim 1	$2,831.76	2 $894.24	$3,726.00
3 Claim 2	$3,726.00	–	$3,726.00
4 Claim 3	$1,863.00	–	$1,863.00
5 Total	$8,420.76	$894.24	$9,315.00

To summarize the example above, the total claims payment was $9,315.00 with $8,420.76 paid directly to the Provider and $894.24 paid to the IRS for the benefit of the Provider as prepaid federal tax. In this example, The Health Plan received a signed IRS Form W-9 from the Provider after Claim 1 was processed, therefore no backup withholding was made on Claims 2 and 3.

If your claims payments have been reduced by Federal Backup Withholding:

1. Do not balance bill the member for federal backup withholding reported on Provider vouchers.
2. Submit a signed IRS Form W-9, Request for Taxpayer Identification Number, to The Health Plan.

Backup withholding will be removed from future Provider payments within 30 days of receipt of a valid Form W-9.

Post-Acute Care Prior Authorization Waived

Until Further Notice Due to Increase in COVID-19 Hospitalizations

Effective September 1, 2021 due to the increase in hospitalizations and ICU admissions from COVID-19 THP and eviCore are waiving prior authorization for Post-Acute Care for all fully insured lines of business until further notice. Please note this does not apply to self-funded plans.

This includes:

- Long-term care facilities
- Skilled nursing facilities (SNF)
- Inpatient rehab facilities
- Home health

* Excludes SUD Residential

Provider Education

Medicaid Targeted Case Management

The Health Plan supports care management as an evidence-based method for integrating behavioral health and medical care. However, West Virginia Medicaid Targeted Case Management (TCM) has clearly specified "guiderails" for eligibility and service.

According to BMS Chapter 523, an adult member is eligible to receive TCM under the following circumstances:

1. Documentation indicates that an adult member is eligible for TCM because:
   a. The adult is age 22 or older; and
   b. By virtue of age and effects of the emotional and/or developmental impairments, the adult is unable to perform activities of daily living (ADL) without assistance and/or prompting, and
   c. The adult demonstrates a serious and persistent emotional, behavioral, developmental and/or substance use disorder as exemplified by a valid diagnosis as described in the language of the current Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association; and/or the current International Classification of Disease and Related Health Problems (ICD).

OR

2. Documentation indicates that the adult is currently and temporarily residing in a licensed domestic violence shelter

Note that all three circumstances are required under the first category of eligibility.

Additional criteria from the manual include:

In order to demonstrate the linkage between emotional/behavioral/developmental disability and functional impairment, the provider's documentation must reflect one or both of the following:

1. Because of inability to process and comprehend information, the member is unable to properly act upon documents or utilize processes regarding benefit eligibility, medication management, budgeting, or otherwise performing activities required to continue to live in a community based setting;
2. Because of interpersonal problems of psychiatric symptomatology, the member is unable to cooperate with others in order to achieve goals and obtain services necessary for community living.

Because the care manager relationship to the member is designed to be relatively intimate and supportive, billing for multiple case managers within one agency on the same member is generally not appropriate. Each care manager should be trained and certified by the agency under the guidelines specified for Targeted Case Management in the manual, and appropriately supervised.

Examples of activities which are NOT appropriate for Targeted Case Management billing include the following:

1. Quality and completeness reviews of member records;
2. Preparation of urine drug samples to be sent to the lab;
3. Reviews of UDS results in Medication Assisted Treatment programs;
4. Billing that duplicates TCM billing by another staff person in the same time frame performing different TCM activities;
5. Billing by different case managers on the same member (exceptions can be made for unusual circumstances);
6. Preparation of group therapy workbooks; and
7. Calls from front desk staff as appointment reminders.

Telemarketing Schemes

Providers Beware

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

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

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

The pharmacy will fax or send a pre-filled in form to the physician office requesting signature. The pharmacy then submits a claim for these creams, typically at a grossly inflated cost. In some instances, they bill thousands to tens of thousands of dollars for small quantities of the cream, if it is sent out to the patient at all. In many cases, these creams contain medications that in whole or part are not FDA approved or not approved for topical use. In other instances, the creams do not even contain the substances the pharmacy is billing for.

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

What Can You Do to Help?

Please be alert to these scams and be cautious of what you are signing. Be sure that these creams, supplies or other various types of equipment are truly needed for your patients. Remember, by signing the form, you could be putting yourself at risk as well. Make sure your patients know what YOU think they need in terms of supplies, equipment and treatment. Often educated members are proving to be on the front line for discovery of these scams.

How to Protect Your Patient from Phone Scams

Remind them:

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

Pharmacy Management Updates

We may add or remove drugs from our formularies during the year. To inquire about the status of a drug on the formulary, please visit healthplan.org.

We may update policies throughout the year. The most up-to-date policies are located on the secure provider portal at healthplan.org.

Affirmative Statement Regarding Incentives

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

Facility Transfers Require Prior Authorization

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

Talk to Patients

Advance Directives

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

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

The HealthPlan

1110 Main Street
Wheeling, WV 26003-2704