ProviderFocus
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REMINDER: Signatures, Credentials and Dates Are Important

THP requires that each entry in the patient's medical record contain an acceptable signature, credentials, and the date on which the provider performed a service. Visit the Centers for Medicare and Medicaid Services (CMS) website at cms.gov for more information on signature requirements.

Inside this issue …

Employment Requirements

Peer Recovery Support Services Specialist (PRSS)

THP offers the following employment requirements and clarification as a follow-up to the Peer Recovery Support Services (PRSS) article that appeared in THP's fourth quarter 2021 ProviderFocus newsletter. The requirements below are per the Bureau for Medical Services (BMS) Provider Manual Chapter 504.

Until October 1, 2022, BMS will accept any PRSS specialist certification completed prior to July 1, 2018, with an 80% or higher score. Also acceptable is a West Virginia Certification Board for Addiction and Prevention Professionals (WVCBAPP) certification completed at any point prior to rendering services for a WV Medicaid member.

Beginning October 1, 2022, WVCBAPP certification will be required for all existing and new PRSS specialists. Other employment requirements include:

- Current CPR/First Aid card and
- Fingerprint-based background check (please see BMS' Provider Manual Section 504.4 for more information) and
- The individual must be employed by either a Community Mental Health Center (CMHC) or Licensed Behavioral Health Center (LBHC)
- Documentation of all requirements, including certification, must be maintained in the PRSS personnel files by the CMHC or LBHC

According to BMS, the term "employed" is interpreted as meaning that the PRSS specialist must be an employee of the CMHC or LBHC and not an independent contractor.

Clinical Documentation Guidelines

THP requires a consistent, legible, responsible method of record keeping for all provider entities. These guidelines will provide entities with standards to ensure medical record documentation is pertinent, accurate, and complete for all services performed. Failure to follow the guidelines may result in a delay, claim processing errors, or denial.

1. All medical records must be easily readable and clear. Illegible records potentially affect patient care and cannot be appropriately reviewed, resulting in claim denials.
2. Signatures:
   a. All records used to document services rendered for payment must be appropriately signed by the individual including their credentials.
   b. Signatures may be handwritten, initialed over a typed or printed name, or may be authenticated electronic signatures. If a signature is handwritten and illegible, it must be accompanied by a typed or printed copy of the signature including credentials.
   c. Electronic signatures must include a date and time stamp and the provider's name and credentials. Stamped signatures are not acceptable. Credentials may be listed in the letterhead of the record.
   d. Signatures of supervisory personnel must occur (indicating review and approval of the documentation) within one week of the visit. Supervisors are responsible for the quality of the supervisee's documentation and timeliness of entry.
3. Time-based services: Services that are time based (billable by a specific unit of time) must include the duration, preferably stated in start, and stop times, often required by Mountain Health Trust (MHT) guidelines. The West Virginia Medicaid Provider Manual Chapter 519 requires that the time the practitioner spent with the member for medical decision-making be documented when the claim is for evaluation and management (E/M) codes. Click here for more information.
4. Timeliness:
   a. The Centers for Medicare and Medicaid Services (CMS) require that documentation be signed "as soon as practicable after the service is provided to maintain an accurate medical record". The provider entity must have a policy regarding timeliness of signature for the provider of clinical services as well as any required signing by supervisors. The Health Plan's standard policy requires documentation to be signed within 72 hours unless stated otherwise in the record and will apply if the provider has no such policy.
   b. Entries should not be made in advance of a service rendered.
   c. Exceptions can be made if explained or justified within the clinical record.
5. Altered, amended or addended medical records:
   a. The medical record cannot be altered. Corrections may be made, so long as the original documentation remains and is clearly marked as corrected.
   b. Providers may not write over, white out, delete, or erase a prior entry. The correction should be marked through with a straight line, initialed and dated, and followed by the correct information with the current date and initials.
   c. Electronic records must clearly identify the original error and the correction, date and time of correction, individual correcting, and reason for correction.
   d. Addenda may be made only when the correct information was not available at the time of the original documentation. Exceptions may be made for entries that are accidentally entered into the incorrect patient file. Addenda should be the exception rather than a rule. At a minimum, addenda must include:
      i. Statement indicating that the entry is an addendum,
      ii. Date and time the record is being amended,
      iii. Details of the amended information and,
      iv. Signature of the provider writing the addendum

6. Templated, Copy and Paste, or Replicated medical records:
   a. Each medical record must be specific to the individual served. While templates may be used, there must be evidence other than check marks that individual treatment was provided, even in group settings. An individual with knowledge and/or experience in a relevant field reviewing the medical record must be provided with sufficient information in the clinical record to allow understanding of the member's current condition and the services provided. If the member has a master treatment plan, the treatment provided should refer to the goals and objectives of the master plan and provide information as to the issues addressed in the visit and the member's unique status at the time of treatment.
   b. Documentation must be specific to the patient and his/her situation at the time of the encounter.
   c. Documentation that is copied and pasted from one visit to the next or from one patient to another is not permitted.
   d. Clinical documentation can only be carried forward if it is accompanied by dated and signed documentation updating member status individually, as described above.
7. The clinician may add explanation in the medical record for anomalies in entries that will be reviewed by THP.

Please reference the following articles shared by CMS and BMS on documentation guidelines:

- WV Bureau of Medical Services Chapter 519.8 Practitioner Services: dhhr.wv.gov/bms/Provider/Documents/Manuals/Chapter%20519%20Practitioner%20Services/Chapter%20519.8-Practitioner%20Services%20FINAL.pdf
- CMS Documentation Matters Toolkit: cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program/Education/Documentation
- AMA Implementing CPT Evaluation and Management Revisions: ama-assn.org/practice-management/cpt/implementing-cpt-evaluation-and-management-em-revisions
- MLN Matters Complying with Medicare Signature Requirements: cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/signature_requirements_fact_sheet_icn905364.pdf

The Health Plan's Affirmative Statement Regarding Incentives

THP bases its decision-making for coverage of healthcare services on medical appropriateness utilizing nationally recognized criteria. The Health Plan does not offer incentives to providers or employees involved in the review process for issuing non-authorization nor does The Health Plan specifically reward, hire, promote, or terminate practitioners or other individuals for issuing denials of coverage. Also, The Health Plan does not offer incentives that foster inappropriate under-utilization by the provider, nor do we condone under-utilization, nor inappropriate restrictions of healthcare services.

Pharmacy Management Updates

THP may add or remove formulary drugs during the year. To view a list of formulary drugs and/or initiate the formulary exception process, please visit THP's corporate website: healthplan.org. Search under "For You & Family" "Pharmacy" "Formularies."

Out-of-Network and Tertiary Facility Transfers Require Prior Authorization

THP requires prior authorization before transferring patients to an out-of-network or tertiary facility. If you are unsure of a facility's status with THP call THP at 1.800.624.6961 To request prior authorization, visit our secure provider portal.

Substance Abuse Screening & Monitoring

The opioid crisis continues to be an area of concern in the United States and especially among the Centers for Medicare and Medicaid Services (CMS) population. In 2019, 10.1 million people misused prescription opioids in the past year[1]. In 2020, 9.3 million people misused prescription opioids in the past year[1].

To do our part in helping to combat this issue, THP recommends screening patients receiving chronic opioids for abuse and/or diversion. Diversion can be assessed utilizing urine or blood samples. Screening tools to detect abuse include the Rapid Opioid Dependence Screen (RODS) or the Opioid Use and Side Effects (OWLS) tool. For patients that receive positive scores, the CDC recommends further evaluation using the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) criteria[2].

For patients that receive a diagnosis of opioid use disorder, THP recommends consideration of medication assisted treatment (MAT) by an authorized provider or referral to a pain specialist and/or treatment addiction provider. For providers that have this authorization, the American Society of Addiction Medicine National Practice Guidelines for the Treatment of Opioid Use Disorder is a recommended resource that covers MAT options like:

- Methadone
- Buprenorphine
- Naltrexone[3]

For patients requiring both chronic and acute opioid therapy, THP recommends utilizing Prescription Drug Monitoring Programs (PDMPs). PDMPs are statewide electronic databases that track all controlled substance prescriptions. Authorized users can access records on medications and doses dispensed. PDMPs have been proven to improve patient safety by identifying patients that are receiving opioids from multiple providers and who may be receiving other medications that increase the risks associated with opioids such as benzodiazepines. Regulations among different states vary, although the CDC recommends checking the PDMP at least once every 3 months and prior to writing every opioid prescription[4].

References:

1. US Department of Health and Human Services: About the epidemic [updated October 27, 2021]. Accessed March 3, 2022. Available at: hhs.gov/opioids/about-the-epidemic/index.html
2. CDC: Drug overdose training. Accessed March 3, 2022. Available at: cdc.gov/drugoverdose/training/oud/accessible/index.html
3. The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update. J Addict Med. 2020 Mar/Apr;14(2S Suppl 1):1-91. doi: 10.1097/ADM.0000000000000633. Erratum in: J Addict Med. 2020 May/Jun;14(3):267. PMID: 32511106.
4. CDC: Prescription drug monitoring programs (PDMPs) [updated February 12, 2021]. Accessed March 3, 2022. Available at: cdc.gov/drugoverdose/pdf/PDMP_Factsheet-a.pdf
5. "2020 National Survey of Drug Use and Health (NSDUH) Releases." SAMHSA, 1 July 2022, samhsa.gov/data/release/2020-national-survey-drug-use-and-health-nsduh-releases

HIPAA Compliant Denial Codes

Health Insurance Portability and Accountability Act (HIPAA)

THP provides a one-to-one distinct Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) with every denial which offers additional clarity for providers and members in reviewing their remittance advice and explanation of benefits.

No Surprises Act Compliance

Provider Information Accuracy

THP values and recognizes the important role physicians and practitioners play in maintaining the health and well-being of the communities we serve.

To help THP members identify the location(s), phone number, office hours and other provider information about your practice, THP has been calling your practice once every ninety days to verify physician and practitioner information. This quarterly validation is required by federal regulation, called the No Surprises Act (NSA), which became effective January 1, 2022 and includes a provision, Section 116, to improve the accuracy of provider directory information. NSA further requires that if verification and attestation does not occur, health plans are expected to suppress unverified provider information from their provider directory.

To be NSA compliant in an operationally efficient manner, THP partnered with the Council for Affordable Quality Healthcare (CAQH) to leverage their directory accuracy solution, Provider Directory Snapshot. CAQH's directory accuracy solution replaces the quarterly phone calls to your practice with electronic self-verification.

If you are a CAQH enrolled provider, log into CAQH ProView® and review and edit your profile information as necessary.

New to CAQH? You may have received an introductory email from CAQH ProView with a registration link included. If an e-mail was not received, please go to the link provided below and click on "Register Now."

Visit proview.caqh.org to get started.

Change Healthcare is THP's Exclusive EDI Gateway

Change Healthcare (CHC) is the exclusive electronic data interchange (EDI) gateway for The Health Plan (THP). Electronic claim files (837) and electronic remittance vouchers (835) must be directed through CHC by using payer ID number 95677 or 34150.

To enroll for electronic vouchers, complete the Billing and EDI Authorization and Setup Form located on our secure provider portal. Completed forms may be sent directly to credentialing@healthplan.org or via fax to 740.699.6169.

Prepayment Review

Identifying Inappropriate Billing Patterns

THP is committed to ensuring quality care for our members and proper payment to our providers. As a participant in federal and state funded healthcare programs, THP is obligated to have systems and procedures in place to guard against fraud, waste, and abuse. THP utilizes several program integrity tools such as Prepayment Review. Prepayment Review is used to satisfy THP's oversight obligations and responsibilities for the Mountain Health Trust line of business (WV Medicaid and WVCHIP). The goal of the prepayment review is to identify inappropriate billing patterns, educate providers on billing in accordance with industry standards, and prevent future inappropriate billing.

Prepayment review may be utilized when questionable billing patterns are identified or if a particular provider is deemed to be at high-risk of fraud, waste, and abuse. Providers may be identified via referrals from the Bureau for Medical Services (BMS) or as a result of internal monitoring including, but not limited to, routine claims processing and targeted data mining.

The Prepayment Review Policy can be found on our corporate website healthplan.org "For Providers," "Medicare and Medicaid," "WV Medicaid."

Low Income Medicare Beneficiaries

The QMB (Qualified Medicare Beneficiary) Program is a Medicaid benefit that pays Medicare premiums and cost sharing for certain low-income Medicare beneficiaries. Federal law prohibits Medicare providers from collecting Medicare Part A and Part B co-insurance, copayments, and deductibles from those enrolled in the QMB Program, including those enrolled in Medicare Advantage and other Part C plans. If you are a PCP, THP has coded your patient rosters with a symbol to help you identify which of your patients meet this income level. Patient rosters are available on our secure provider portal located at myplan.healthplan.org. 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. Providers may contact Medicare at 1.800.MEDICARE (1.800.633.4227) for additional information.

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

Prior Authorization

Requirements for Post-Acute Care Re-Instated

Effective June 1, 2022, THP reinstated prior authorization requirements through eviCore for members receiving Post-Acute Care.

Applicable Lines of Business:

- Fully Insured (Commercial Health Maintenance Organization [HMO], Preferred Provider Organization [PPO] and Point of Service [POS]),
- Medicare Advantage (SecureCare HMO, SecureChoice PPO and Dual Eligible Special Needs Plan [DSNP])
- Mountain Health Trust (WVCHIP and WV Medicaid)

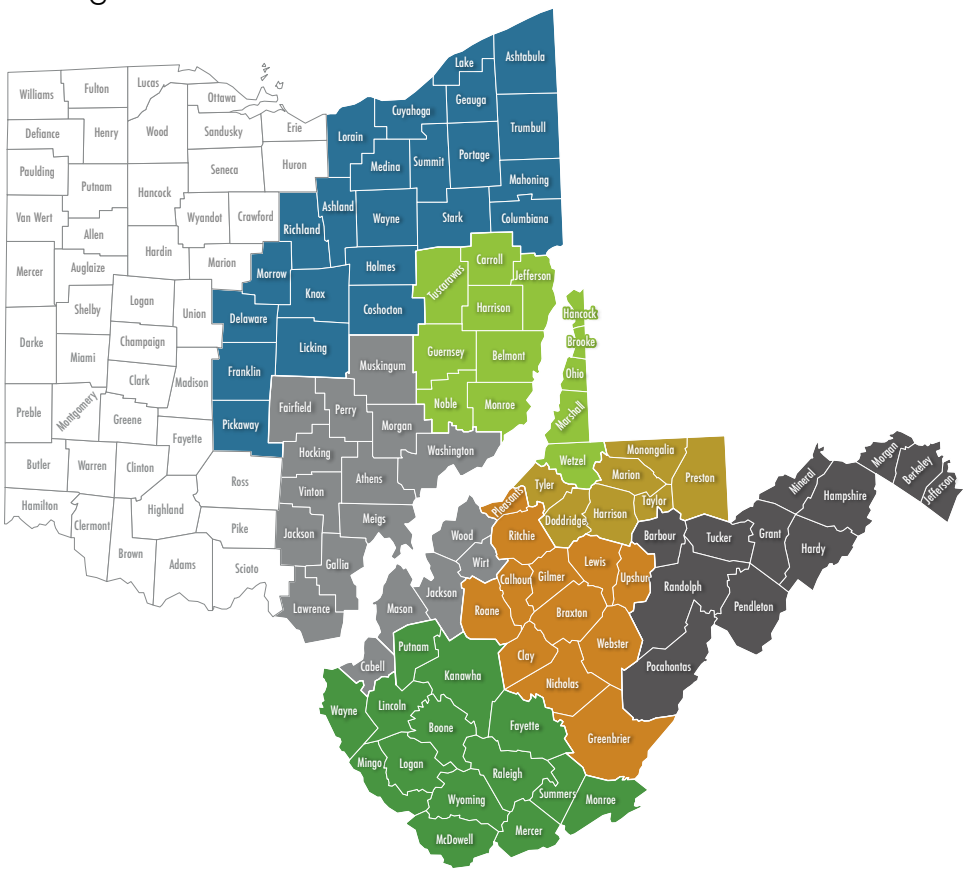
Impacted facilities types:

- Long-term acute care hospital (LTAC)
- Skilled nursing facility (SNF)
- Inpatient rehabilitation facility (IRF)
- Home health

Meet Your Practice Management Consultant

As the healthcare industry continues to evolve, improving relationships with providers, hospitals and health systems is vital in maintaining superior service to our members. To maximize positive member and provider experiences, The Health Plan has a team of Practice Management Consultants (PMC) 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.

Click here to check out our network map and meet your Practice Management Consultant.



Member Rights and Responsibilities

THP's Provider Practitioner Manual describes the member rights and responsibilities in Sections 3 and 5. This manual is available on THP's corporate website, healthplan.org. To obtain a copy please contact the Customer Service department at 1.800.624.6961.

Model of Care for D-SNP: Required Annual Training

The Health Plan has developed a specific model of care (MOC) to help address the complex health care needs of members enrolled in the dual eligible special needs (D-SNP) plan.

The Health Plan's MOC is a written document that describes the measurable goals of the program, along with The Health Plan staff structure and care management roles, and the use of clinical practice guidelines and protocols. The program includes training for personnel and providers, a health risk assessment tool to collect information on the health needs of our members as they enroll and the development of an individualized care plan for each member.

Training materials and the Provider Training Attestation Form are available on The Health Plan's secure provider website (myplan.healthplan.org) in the Resource Library, under "Training and Education."

Hours of Operation Reminder

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.

We Want to Hear From You

The Health Plan (THP) would love to hear your suggestions for articles to include in upcoming newsletters. Feel free to e-mail providersupport@healthplan.org with your ideas as we tailor to your needs.

Gold Star Program

Effective September 1, 2022

THP's Gold Star program is designed to recognize health care practitioners who meet outpatient prior authorization volume and approval criteria by eliminating the prior authorization process for twelve months following initial Gold Star Program enrollment.

To qualify for THP's Gold Star Program, when practitioner requested 30 or more prior authorizations in a twelve-month period and obtained a prior approval percentage greater than or equal to 90%, THP will not require prior authorizations from that practitioner for the next twelve-month period, except for experimental/investigational services or procedures and all out of network service requests.

THP's Gold Star program is available to all participating providers in THP's direct contracted network in all states and for all product lines (Commercial, ASO, WV Medicaid, WV CHIP, and Medicare Advantage).

THP's Practice Management Consultants (PMC) will contact qualified Gold Star providers to inform them of their program effective date.

30+

Prior Authorizations in a **12** Month Period

Prior Approval Percentage Greater Than or Equal to

90%

THP Will Not Require Prior Authorizations from that Practitioner for the Next

12

Month Period*

TheHealthPlan

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