ProviderFocus
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REMINDER: Signatures, Credentials and Dates Are Important

Each entry in the patient's medical record requires the author's signature, including credentials and the date of the person writing the note.

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New Opioid Prescription Management Rules for Medicare Members

Effective January 1, 2019 the following prescription coverage rules will be implemented for SecureCare/SecureChoice members.

Opioid Naïve 7-day Supply Limit:

- An opioid naïve safety edit will limit a member's opioid to a 7-day supply if the member has not used an opioid in the past 180 days.
- A provider can request an override, however, the criteria for approval would need to be met (criteria may be found on healthplan.org).

Care Coordination 90 Morphine Milligram Equivalent (MME) Edit:

- A coordination of care edit will occur when a member's cumulative opioid MME amount reaches or exceeds 90 MME in the past 180-day period.
- The pharmacist will be required to address the edit before the prescription can be dispensed.
- Pharmacists may override edits for known exemptions, including long-term care, hospice, palliative or end-of-life care and cancer.
- If none of the above exemptions are known the pharmacist must contact the prescriber.
- The pharmacist will consult with the prescriber and after the prescriber confirms intent, the pharmacist will document the discussion and use an override code to allow the prescription to process.

We ask that prescribers who receive calls from dispensing pharmacists respond in a timely manner. Failure to coordinate with the pharmacist could delay the patient obtaining their prescription.

If you have any questions, you may contact Pharmacy Services at 1.800.624.6961, ext. 7914.

THP Partners with Palladian Health™

Effective January 14, 2019

As part of our commitment to providing programs that support 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, web-based self-management tools and a cognitive behavioral therapy telehealth program.

Palladian Health spine care management includes services provided to individuals covered under all commercially insured fully-funded plans (including HMO, PPO and POS plans), all Medicaid plans, and all Medicare Advantage plans (does not include services provided to participants in self-funded plans). Diagnostic imaging reviews, MRI, etc., continue to be completed by The Health Plan. A complete list of CPT codes that are included in the Palladian Health prior authorization process can be found on THP's website located at healthplan.org/preauth.

How does this partnership affect you?

Beginning January 14, 2019, Palladian Health will be performing prior authorization and medical necessity reviews 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.
- All PT and OT - all services after initial evaluation require prior authorization and medical necessity review by Palladian Health. No referral or prior authorization is required for the initial evaluation and members may self-refer for evaluation. Services related to treatment of autism spectrum disorder will continue to be managed by The Health Plan Behavioral Health Services.
- All chiropractic care – all services after initial evaluation require prior authorization and medical necessity review by Palladian Health. No referral or prior authorization is required for the initial evaluation and members may self-refer for evaluation. All X-rays performed in the chiropractic setting require prior authorization and review by Palladian.

Medical necessity review and prior authorizations may be completed through The Health Plan online portal located at myplan.healthplan.org/Account/Login, via fax at 1.844.681.1205, or telephonically at 1.877.244.8514. Questions on this new process may be addressed to The Health Plan at 1.877.847.7901 or by contacting your provider engagement representative.

Member Rights and Responsibilities

We would like to remind all provider offices that the member rights and responsibilities can be found in the Provider Procedural Manual, Section 3. 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.

SilverSneakers®

Fitness is Medicine

SilverSneakers® Fitness, offered through The Health Plan, helps seniors improve their physical and mental health by providing FREE access to thousands of participating fitness locations nationwide, and an active, supportive community.

SilverSneakers includes:

- Trained instructors who specialize in senior fitness, and foster a safe environment for senior members
- Group classes designed for every fitness level
- Weights, pools and cardio-equipment access (varies by location)
- A robust Facebook community with access to on-demand exercise videos
- Social events such as shared meals, holiday celebrations and class socials

SilverSneakers has a proven impact on members' physical and emotional health. Start the conversation. Your voice matters in keeping patients active—encourage them to start using this free benefit today. Members can visit SilverSneakers.com/StartHere or call 1.888.423.4632 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. ET.

REMINDER: CMS Annual Training Requirements

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.

You are required to maintain evidence of training for 10 years. This may be in the form of attestations, training logs or other means.

THP Affirmative Statement Regarding Incentives

The Health Plan bases its decision-making for coverage of healthcare services on medical appropriateness utilizing nationally recognized criteria. Incentives are not offered to providers or employees of The Health Plan involved in the review process for issuing non-authorization nor does The Health Plan specifically reward, hire, promote, or terminate practitioners or other individuals for issuing denials of coverage. Also, no incentives are given that foster inappropriate under-utilization by the provider, nor does The Health Plan condone under-utilization, nor inappropriate restrictions of healthcare services.

REMINDER: Prior Authorizations

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

Medication Reconciliation

Post-discharge HEDIS Coding Tips

Medication reconciliation is the process of reviewing and comparing discharge medications with the current medication list to ensure safety. The Medication Reconciliation Post-Discharge (MRP) quality measure assesses members 18 years of age and older for whom medications were reconciled on the date of discharge through 30 days after discharge. The measure includes all acute and non-acute inpatient discharges, including but not limited to hospitals, skilled nursing facilities, and rehabilitation facilities.

Reconciliation documentation should be present in the outpatient record and should include evidence of the review and the date when it was performed. This quality measure is based on discharges, not on members, therefore a review should be completed within 30 days of each discharge. Listed below are the applicable codes to be billed for a medication reconciliation review.

Medication Reconciliation CPT:
99483, 99495, 99496, 1111F

Behavioral Health Care and Primary Care Practitioners

Continuity and Coordination of Care

Continuity and coordination of care between behavioral and physical health care providers is an important aspect in the delivery of quality health care as behavioral and medical conditions can interact to affect an individual's overall health.

All federal and state confidentiality laws must be followed. The Health Plan expects that this information be shared accordingly and recognizes the right to keep progress notes private. The Health Plan also understands that there are special situations where information cannot be shared. Visit our website for resources to facilitate the continuity and coordination of care, including a helpful consultation sheet.

Annual D-SNP Provider Training

Learn More About The Health Plan's Medicare/Medicaid Dual-Eligible Plan

The Health Plan offers a Medicare Advantage Dual-Eligible Special Needs Program (D-SNP) in West Virginia and Ohio. The D-SNP program targets special populations who are individuals entitled to Medicare and are also eligible for some level of assistance from their state Medicaid program. Their services are coordinated so that the member obtains the maximum benefits of their dual coverage. Annual D-SNP provider training is required by CMS.

The Health Plan's provider website offers a presentation to further explain the program and features of the navigation process. We encourage you to visit the website at healthplan.org/providers/support-and-service/compliance-fraud-waste-and-abuse.

Once you have reviewed the training, please click the back arrow in your web browser and scroll to the bottom of the page to complete The Health Plan Attestation Form and click "Submit". If you are uncertain if you have completed your annual D-SNP training please contact providersupport@healthplan.org.

2018 Practitioner Experience Survey

Help Us to Help You!

Evaluation of overall practitioner experience with The Health Plan provides objective data to help us create action plans that improve interactions and remove any potential barriers to care. The survey is conducted annually every Spring.

In 2018, there were 700 practitioner experience surveys mailed to primary care physicians (PCPs), behavioral health practitioners and secondary care physicians (SCPs). We received 90 responses for a return rate of 12.86 percent. The return rate remains low but is up from the previous year. Survey Monkey was utilized in 2017 for the practitioner experience survey which may have accounted for a lower rate of return. With the return to mailed surveys in 2018, the rate of response increased by 7.16 percent.

An internal benchmark of 90 percent positive response rate for all questions is The Health Plan's goal. Responses for 2018 remained positive and on track but did identify provider interest in additional information and education regarding:

- THP disease management programs and feedback about their enrolled patients;
- Case management programs and how THP case managers can help their patients access services, AND;
- Medical director accessibility for discussion of review decisions.

The Health Plan uses this information to help plan seminars, newsletter articles, email blasts, and other correspondences to increase understanding and improve communication between you and our staff. Additionally, we have a dedicated team of provider engagement representatives who are available for face-to-face visits to support provider education, individualized needs and questions. Our provider engagement representatives can be reached at 1.877.847.7901.

Providers may call the Medical Management Department for peer-to-peer review discussion, support with THP member programs or questions at 1.800.624.6961, ext. 7644 or 7643 or Behavioral Health Services at 1.877.221.9295.

Prior Authorization Not Required

For Fully-Funded and Select Self-Funded Plans

As the opioid epidemic continues to plague our nation, immediate access to medication assisted treatment (MAT) is more important than ever. Effective January 1, 2019, The Health Plan will remove prior authorization requirements for all buprenorphine-containing medications for the treatment of opioid addiction for fully-funded and select self-funded plans (based on client preference) only. Removal of prior authorizations will eliminate a significant roadblock for physicians wishing to prescribe MAT for immediate use by their patients. Questions may be directed to the Pharmacy Department at 1.800.624.6961, ext. 7914.

Caring for Medicare Members

Low Income Medicare Beneficiaries

The Qualified Medicare Beneficiary (QMB) Program is a Medicaid benefit that pays Medicare premiums and cost-sharing for certain low-income Medicare beneficiaries. Federal law prohibits Medicare providers from collecting Medicare Part A and Part B co-insurance, copayments and deductibles from those enrolled in the QMB Program, including those enrolled in Medicare Advantage and other Part C plans. Most of The Health Plan's DSNP members are QMB. THP has coded PCP rosters to help you identify your patients that meet this income level. Patient rosters are available on our secure provider portal.

Your patients should make you aware of their QMB status by showing both their Medicare and Medicaid or QMB card each time they receive care. Patients should not get a bill for medical care that Medicare covers. Patients cannot be charged for Medicare deductibles, co-insurance and copayments.

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

Prior Authorization Requirement and Coverage Guideline

Clinical Drug Testing

Effective July 1, 2018, based on The American Society of Addiction Medicine's (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.

View ASAM's guidelines Here: asam.org/resources/guidelines-and-consensus-documents/npg

THP received additional guidance from BMS regarding Medicaid urine drug testing (UDT) and definitive testing. For a detailed guidelines for WV Medicaid, visit BMS's website: dhhr.wv.gov/bms/Pages/Chapter-529-Laboratory-Services.aspx

For detailed guidelines for all other lines of business (Fully-Funded Commercial, TPA and Medicare), visit CMS's website: cms.gov/medicare-coverage-database/overview-and-quick-search.aspx

Helping Members Who Suffer from Catastrophic Medical Issues

Case Management Program

The Health Plan has registered nurses that are certified case managers to coordinate health care services for members with catastrophic illnesses, injuries or behavioral health problems. If you have a patient you think would benefit from the case management program, you can contact the case managers by calling the Medical Department toll-free at 1.800.624.6961, ext. 7644 or 7643. Contact the Behavioral Health Services at 1.877.221.9295.

For additional information on these programs, visit our website at healthplan.org. Here you'll find detailed information on the program and our Behavioral Health Services offers an easy-to-use online referral form.

Bridging the Gap

Between MAT Providers and PCPs

The Health Plan employs behavioral health nurse navigators that are available to bridge the gap between medication-assisted treatment providers and primary care physicians to support members as they navigate their way through their substance use disorder treatment.

Call us at 1.877.221.9295 to speak to a behavioral health nurse navigator.

The Substance Abuse and Mental Health Services Administration (SAMHSA) offers a free mobile app, MATx to empower practitioners to provide effective, evidence-based care for opioid use disorder. Visit store.samhsa.gov/apps/mat for more information and to download MATx.

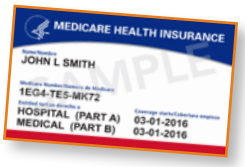
Available Online

Clinical Practice Guidelines

The Health Plan and participating practitioners review and update the preventive health guidelines and clinical practice guidelines, which are available to you as a reference tool to encourage and assist in planning your patients' care. To help make the information more accessible and convenient for you, we post the complete set of guidelines online. Just visit healthplan.org/providers/quality-measures to view standards, guidelines and program descriptions for quality improvement, disease management and behavioral health practice guidelines.

New Medicare Card

Ohio Mailing Underway



If your Medicare patients say they did not get a card, instruct them to:

- Sign into MyMedicare.gov to see if CMS mailed their card. If so, they can print an official card. They must create an account if they do not already have one.
- Call 1.800.MEDICARE (1.800.633.4227). There might be something that needs to be corrected, such as updating their mailing address.
- Unless a change has occurred in coverage, Medicare Advantage members will not receive a new card from The Health Plan.

REMINDER: Keep Your Information Up-to-Date

In the electronic age of direct deposit, remittance advices and electronic claims submissions, it's important to notify The Health Plan of any changes to ensure you receive this information. Please be sure to notify us of any changes, such as a change in your physical location, telephone number, back up coverage, hospital affiliation and practice restrictions. All of this information is gathered in order to provide the most current information to our members in the form of directories, whether they are electronic or paper.

Please follow these simple steps to verify your information:

1. **Visit our website, healthplan.org**
2. **Select Find a Provider**
3. **Under Commercial Member, click "Search Online"**
4. **Under "Step 1," enter your last name only.**
5. **Under "Step 2" select "All" and click "Search."**
6. **Click on your practice/facility's name to view full details. Review all information to verify that it is still current.**
7. **Report back confirmation of your practice information as it appears or any changes needed to correct the data to providersupport@healthplan.org**

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.

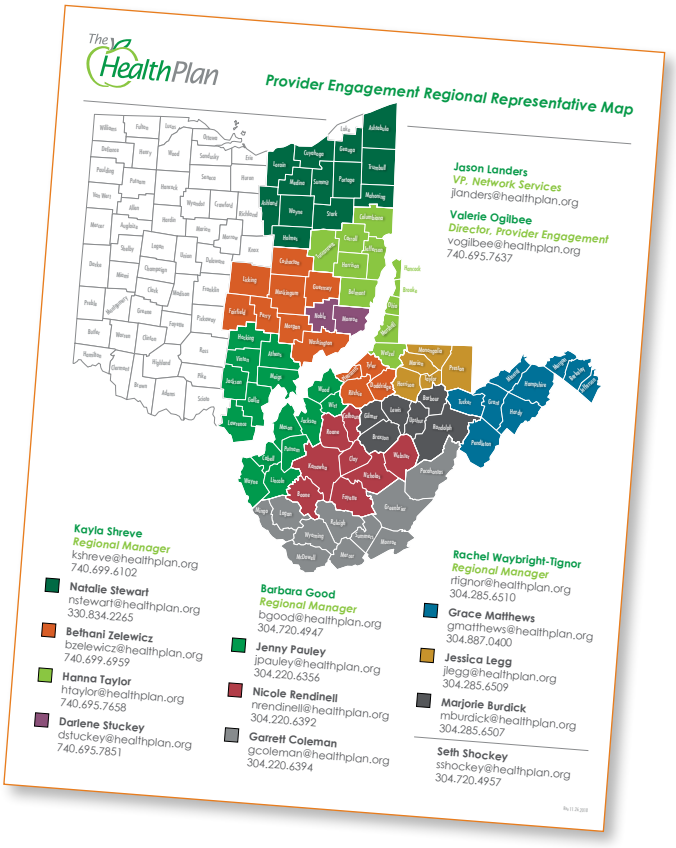
Provider Portal

No Waiting

Tired of waiting on hold for a customer service representative to assist you? Wondering if you received a fax document? Utilizing The Health Plan's provider secure web portal can save you time and hassle. On our provider secure portal you have the ability to:

- View member eligibility and copays
- Submit a pre-authorization request
- Download member rosters
- View claims information in real time
- And more!

What are you waiting for? Register for access to the provider portal at myplan.healthplan.org/Account/Login. Contact your provider engagement representative to receive a tutorial on how to utilize this site.



The HealthPlan

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