



ProviderFocus

A Publication of The Health Plan • April 2019

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.

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Shaping Health Risks and Outcomes Social Determinants of Health

Social determinants of health (SDoH) are conditions that shape a patient's health risks and outcomes, including where people are born, live, learn, work and play. There has been a growing interest from healthcare systems across the country considering how to best provide and finance services that address health-related social needs.

CMS has developed an Accountable Health Communities Model that addresses the gap between clinical care and community services.

While this model is still being tested, it is important to understand the data related to SDoH as hospitals and health systems work to improve their communities.

The ICD-10-CM has developed a group of codes available to capture many of these social factors; these codes include Z55-Z65. Historically these codes have been underutilized. However, they are allowed to be reported based on documentation from any clinician involved in care.

It is imperative to educate necessary individuals to collect and report the data. To assist in collecting this data, CMS has developed a quick, 10-item questionnaire called The Accountable Health Communities Health-Related Social Needs Screen Tool (AHC HRSN). This tool can identify patients' needs in the five

core domains that community services can help with: housing instability, food insecurity, transportation problems, utility assistance needs,

and interpersonal safety. The AHC HRSN tool can be found at: <https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf>

For more information on coding for social determinants, please see pages 17-18 of the ICD-10-CM Official Guidelines for Coding and Reporting. <https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2019-ICD10-Coding-Guidelines-.pdf>



Introducing New Claim Editing Software

ClaimsXten by Change Healthcare

The Health Plan will be implementing ClaimsXten, a new claims code editing software. This product was developed by Change Healthcare (previously McKesson) and it, or similar products, are widely used throughout the healthcare industry by Medicaid managed care organizations, health insurers, and third party administrators across the nation to improve payment accuracy, reduce appeals and realize medical and administrative savings.

ClaimsXten will provide the following benefits:

- Increased clinical and administrative savings through the effective and targeted application of up-to-date claim review protocols.
- Payment policies will be applied consistently and transparently.
- Manual interventions will be reduced, which improves claim turnaround times.
- Rules are clinically based and validated by a national panel of clinicians and medical experts.

Many of these edits are being applied to your claims already. This product will assure that the edits are applied consistently and will reduce manual intervention. The rules are clinically based and validated by a national panel of clinicians and medical experts.

Continuity and Coordination of Care

In order to give your patients the best care, working together with the patient, their family/caregiver and other healthcare providers will help develop a continuity and coordination of the care plan. This helps to reduce fragmented care and duplication of medication, tests or services which commonly occurs with inadequate sharing of clinical information. Sharing clinical information helps to improve occurrences of avoidable admissions and readmission. When patients, families, and health professionals work together as partners to improve healthcare it can lead to measurable improvements in safety and quality.

This product currently includes but is not limited to the following types of edits:

- CPT-to-CPT procedures
- Diagnosis-to-procedure options
- Medicare and Medicaid-related auditing logic in the Correct Coding Initiative (CCI)
- Other Centers for Medicare and Medicaid Services (CMS) carrier directives
- Some specific types of editing will include:
 - Deleted codes
 - Gender edits
 - Age edits
 - Pre-operative visit, same day visit, post-operative visit
 - Frequency validation: once or multiple times per date of service
 - Bilateral
 - Multiple code rebundling, multiple surgery, and assistant surgeon edits
 - Unbundling: incidental, mutually exclusive and visits are widely being used

Correction to Medicare Opioid Prescription Announcement

An error was made in the 2018 fourth quarter issue of the Provider Focus regarding the opioid prescription management rules implemented for Medicare members January 1, 2019. The announcement should have stated an opioid naïve safety edit will limit the member's opioid to a 7-day supply if the member has not used an opioid in the past **108 days** (not 180 days). Additionally, under opioid naïve 7-day supply limit pharmacists may override edits for known exemptions, including long-term care, hospice, palliative or end-of-life care, and cancer.

Out-of-State In-Network and Tertiary Hospital List for PEIA Members

Please review the list below of in-network and tertiary facilities that will be effective July 1, 2019.

A tertiary facility is a facility that The Health Plan has contracted with to provide specialty medical and hospital services that are not normally available through in-network hospitals. Please note that a prior authorization is required to access a tertiary hospital.

All facilities located in West Virginia are considered in-network and will not be affected by this change.



Out-of-State In-Network Hospitals:

- Kings Daughters Medical Center, Ashland, KY
- Tug Valley ARH Reg Med Center, South Williamson, KY
- Garrett County Memorial Hospital, Oakland, MD
- East Ohio Regional Hospital, Martins Ferry, OH
- Marietta Memorial Hospital, Marietta, OH
- Selby General Hospital, Marietta, OH
- Three Gables Surgery Center, Proctorville, OH
- Heritage Valley Beaver, Beaver, PA
- Heritage Valley Sewickley, Sewickley, PA
- Page Memorial Hospital, Luray, VA
- Shenandoah Memorial Hospital, Woodstock, VA
- Warren Memorial Hospital, Warren, VA
- Winchester Medical Center, Winchester, VA

Tertiary Hospitals:

- Allegheny General Hospital, Pittsburgh, PA
- Allegheny Valley Hospital
- Canonsburg General Hospital
- Forbes Hospital
- West Penn Hospital
- UPMC Children's Hospital, Pittsburgh, PA
- Cleveland Clinic Foundation, Cleveland, OH
- Euclid Hospital
- Fairview Hospital
- Hillcrest Hospital
- Avon Hospital
- Lutheran Hospital
- Marymount Hospital
- Medina Hospital
- South Pointe Hospital
- Akron General Medical Center
- Lodi Community Hospital
- Cleveland Clinic Rehabilitation Hospitals

Please contact Customer Service at **1.888.847.7902** if you have any questions.

*Provider networks are subject to change.

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. 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 myplan.healthplan.org. Refer to CMS MedLearn Matters article for further guidance: <https://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).

Reminder to Providers

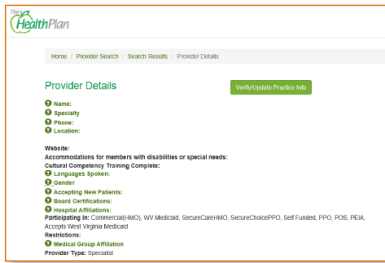


The Health Plan ensures that practitioners offer hours of operation that are no less (in number or scope) than the hours of operation offered to non-Medicaid or non-Medicare members.

New Feature to Assist with Updating Provider/Practice Information

The Health Plan has instituted a new feature to assist providers in verifying and updating information on our website. It is located on the Find a Doc tool found on our website, www.healthplan.org.

1. Click **“Search Online”** under any contracted line of business
2. Under Step 1, enter your last name only
3. Under Step 2, select **“All”**
4. Click on the **“Search”** button at the bottom of the page.
5. Click on the appropriate underlined full name of the practitioner.



Your provider detail information will be displayed for review. A new button now displays to the left of **“Provider Details”** that says **“Verify/Update Practice Info”**. Providers (and members) can click that button which directs them to another page. The new page gives you the option to **“Confirm No Changes”** or to update any erroneous information. The provider (or office staff) will only need their tax ID number and the provider's NPI. Upon submitting the update, the changes are directed to the Provider Support Department to be updated in THP's system.

It is very important to remember to contact The Health Plan with any changes to your office location, telephone numbers, back up physicians and hospital affiliations. All of this information is gathered to provide the most current information in our online and printed directories.

Review Required for Medically-Billable Drugs

Effective April 15, 2019, Current Procedural Terminology (CPT) codes, or J codes, require review for certain medically-billable drugs. Medically-billable drugs are predominantly injectable or infusion drugs that are submitted on a medical claim and are reimbursed based on the member's medical benefit rather than their pharmacy benefit. This affects all lines of business with The Health Plan:

- Commercial (including HMO, PPO and POS plans),
- WV Medicaid (including Mountain Health Trust, WV Health Bridge and SSI),
- Self-funded, and
- Medicare (including SecureCare, SecureChoice, DSNP and Supplemental plans).

A summary of CPT codes requiring review may be found by logging into The Health Plan's secure provider portal at myplan.healthplan.org. The procedure codes contained on the list requiring review and related effective dates are subject to change.



Review requirements may vary by member contract and are separated into three files Medicaid, Medicare, and Commercial/Self-Funded. This is not an all-inclusive list. As this list will be fluid, The Health Plan will provide notice when codes are added/deleted/changed via online provider portal announcements. This information should not be relied on as authorization for health care services and is not a guarantee of payment.

The ordering provider is typically responsible for submitting the medically-billable drug for review. Prior review may be requested electronically via The Health Plan's secure provider portal.

Questions or concerns may be directed to The Health Plan Pharmacy Department at 1.800.624.6961, ext. 7914 or to the provider engagement representative assigned to your county. Please visit <https://www.healthplan.org/providers> to view the provider engagement territory map to locate contact information for your representative.

Well Child Visits and EPSDT

HEDIS® Compliance

Children ages 0-21 should have an annual well-child visit that covers topics including:

- Health history
- Physical developmental history
- Mental developmental history
- Physical exam
- Health education and/or anticipatory guidance
- BMI percentile
- Counseling for nutrition
- Counseling for physical activity
- Immunizations

Completion of the above assessments is in compliance with the following HEDIS® Measures:

- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC), Well-Child Visits in the 3rd, 4th, 5th, and 6th years of life (W34), Adolescent Well-Child Visits (AWC), and Childhood/Adolescent Immunizations (CIS & IMA)
- Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program provides comprehensive health care services to children under age 21, with an emphasis on prevention, early detection, and medically necessary treatment.

The West Virginia EPSDT form was updated in 2018. Utilization of the form keeps you in compliance with the measures listed above while providing a holistic approach to standard of care practice.

The updated EPSDT form allows for a simple, user-friendly means for meeting criteria. You can download and print WV EPSDT forms by visiting <https://dhhr.wv.gov/HealthCheck/providerinfo/Pages/default.aspx>.



DSNP Supplemental Benefits

Members of our dual-eligible special needs plan (DSNP) have supplemental benefits available to help them obtain items and services that they may otherwise not be able to afford. In providing such benefits, we hope to enhance their health status and compliance.

These supplemental benefits include:

- **Over-the-counter items:** A \$60 benefit per quarter is offered for specific over-the-counter items such as: vitamins, aspirin, cold medication, and more from their local pharmacy.
- **Non-emergent medical transportation:** The Health Plan's DSNP Team assists members with coordination of needed transportation to and from covered medical/behavioral health related services. The benefit is limited to 26 round trips or \$600 maximum.
- **Comprehensive dental services:** DSNP members have a comprehensive dental benefit through our partnered vendor, Liberty Dental. The benefit is limited to \$2,000 per calendar year and there is a limit on some services.
- **Hearing Aids:** Hearing aids are covered with a benefit limitation of \$1,500 annually. Batteries and repairs are excluded.
- **Silver Sneakers:** Exercise benefit available at most local gyms or fitness centers.
- **Signify Health:** Contracted vendor that provides in-home assessment for all DSNP enrollees.



The DSNP Care Team or The Health Plan's Customer Service Department are available to assist you or your patients with questions or coordination to services by calling **1.800.624.6961**.

Talk to Patients about Advance Directives

Planning Ahead

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** 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.



Review Determinations

Contacting the Medical Director

When review determinations are disputed or confusing for the attending physician, one available option is sometimes overlooked: A call to the medical director requesting clarification. It's a firm policy of The Health Plan that a medical director will always be available during business hours to discuss such rulings and the reasons behind them. Ordinarily, the conversation needs to take place between two physicians rather than be transmitted through third parties in either office. A determination may change with the addition of new information imparted during a conversation between the two physicians.

When physicians make such an inquiry, you should have the patient's name, referral number and/or ID number available for our medical director to quickly access the electronic record at the outset of the call. It is not mandatory to have this information to initiate a discussion, but without a number to identify the ruling in question the medical director may have to call back after the patient's record has been identified in the system.

Claims and eligibility issues are usually more quickly handled by the Claims Department or the Customer Service Department, but we will help whenever we can. You may reach the medical director at The Health Plan by calling **1.800.624.6961, ext. 7643**.



Be on the Lookout for Practitioner Surveys

If you are a primary care, behavioral health or secondary care provider, then you may receive a practitioner experience survey from us in April. If you receive a survey from us, please take the time to complete and return it, as we use the information obtained to create action

plans to improve interactions and remove potential barriers to member care. Survey results also help us plan webinars, newsletter articles, email blasts and other correspondence to improve communication and collaboration.

The Health Plan All Lines of Business



Some WV provider offices may think that The Health Plan is a managed care organization for WV Medicaid only. We are far more. The Health Plan offers a complete line of managed care products and services designed to provide clients with innovative health care benefits at a reasonable cost.

The Health Plan lines of business are comprised of:

- **Fully-insured commercial plans**, including health maintenance organization (HMO), preferred provider organization (PPO) and point of service (POS) plans
- **West Virginia Public Employees Insurance Agency** (WV PEIA)
- **Medicare Advantage plans** — SecureCare, SecureChoice, DSNP
- **Medicare supplemental coverage**
- **WV Medicaid** — Mountain Health Trust, WV Health Bridge and SSI for medical benefit only
- **Self-funded health plans** — exclusive provider organization (EPO), PPO, POS and HMO plans

Is your staff aware of the plans that you accept? Please discuss The Health Plan lines of business for which you are contracted with. Contact us at providersupport@healthplan.org or your provider engagement representative to receive information on the above lines of business.

Preventive Health Guidelines

In today's busy world, it's not uncommon for patients to wait until they are ill to see a doctor, making it a difficult time to discuss important preventive health issues. To help address this, encourage your members to schedule their yearly well visit so they can get caught up on preventive screenings and immunizations when they are feeling better. Visit our website to view our Preventative Health Guidelines for Children & Adults brochure – it's a great resource to have available for members of The Health Plan and for providers. Contact our Quality Improvement at **1.800.624.6961, ext. 7599** or **740.699.7599** if you'd like a paper copy of this document.

REMINDER: Prior Authorizations

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



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.

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.

Complete for a Chance to Win a Free Lunch DSNP Training

Congratulations to Dr. Cherry Lobaton and the office staff at Valley Health Family Medicine Briarwood for completing their DSNP training and winning lunch delivered by The Health Plan. If you provide services to members with The Health Plan's dual-eligible special needs plan (DSNP), you are required to complete annual training by the Centers for Medicare and Medicaid Services (CMS). Each quarter The Health Plan will draw a winner from the providers that have completed and attested to their DSNP training to receive a catered lunch.

You may view a recording of the DSNP training and attest to the training by logging into your account on our secure provider website, myplan.healthplan.org, or by contacting your provider engagement representative.

Register for a CMS Sponsored Webinar

Join The Health Plan on Wednesday, May 15 at 12:00 noon EST as we host a webinar on The Centers for Medicare and Medicaid Services' (CMS) New Part D Opioid Policies featuring Patrick M. Hamilton, Health Insurance Specialist for CMS. Register for this webinar by clicking this link: <https://attendee.gotowebinar.com/register/5989653761729619715>

After registering, you will receive a confirmation email containing information about joining the webinar.

Palladian Health Presentation Available for Viewing

If you missed any of the Palladian Health webinars in December 2018 and January 2019, or want to view the presentation regarding preauthorization requirements for musculoskeletal and spine pain management again, Palladian's PowerPoint presentation is available on The Health Plan's secure provider portal. Please visit the Announcements section at myplan.healthplan.org.

Note: Member benefits have not changed. Palladian is reviewing pre-authorization requests for medical necessity only. The Health Plan continues to administer benefits and reimburse services per the provider's contract. Pre-authorization is not a guarantee of benefits or reimbursement.



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 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.