TheHealthPlan

Provider Manual

Corporate Office

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healthplan.org

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Chapter 1

About Us & Communicating With Us

Provider Manual

Welcome

The Health Plan of West Virginia Inc. dba The Health Plan (THP) appreciates its physicians, practitioners, hospitals, and ancillary providers and value your dedication and commitment to serve our community.

In 2023, THP redesigned the Provider Manual to make it easier for you to view and find important information, and procedures for all providers participating in our West Virginia, Ohio, and Administrative Services Only (ASO) network.

About Us

THP 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 THP. The plan holds HMO Certificates of Authority in both Ohio and West Virginia. THP currently employs over 500 people throughout three office locations: Wheeling, Charleston, West Virginia, and Massillon, Ohio.

THP has been developing and implementing products and services that manage and improve the health and well-being of its members through a team of health care professionals and partners from across communities since 1979.

Communicating with Us

Our dedicated staff at THP will assist providers and members when issues, questions, or concerns arise. THP's hours of operation are 8 a.m. to 5 p.m. EST Monday through Friday.

We've compiled a quick reference guide that lists important contacts.

Customer Service – Assistance with Benefits, Prior Authorizations, Eligibility, and Claims	
Commercial	1.888.847.7902
Self-Funded	1.888.816.3096
Medicare Advantage	1.877.847.7907
Mountain Health Trust including WV Medicaid and WV Children's Health Insurance Program (WVCHIP)	1.888.613.8385
Behavioral Health	1.877.221.9295
Coordination of Benefits (COB)	1.800.624.6961, ext. 7903
eviCore Healthcare	1.877.791.4101
Emergency Nurse Line (24/7)	1.866.687.7347

Email Contacts	
Electronic Data Interchange (EDI)	edi@healthplan.org
Provider Data Quality (PDQ)	pdq@healthplan.org
Helpful Web Links	
Provider Manual	**healthplan.org/providers/resources/provider-manual**
THP Corporate Website	**healthplan.org**
THP Secure Provider Portal	**myplan.healthplan.org**
Provider Directory	**findadoc.healthplan.org/**
Practice Management Consultant	**https://www.healthplan.org/providers/overview/meet-practice-management-consultant**

Provider Portal

THP's MyPlan Provider Portal offers self-service options and resources. Access the secure provider portal at myplan.healthplan.org to log in or register.

1. **View and Submit Claim Status**
   - Check claim status on all professional and institutional claims submitted to THP regardless of submission method i.e., clearinghouse, portal.
   - Submit professional and institutional claims through the Axiom TransShuttle link on MyPlan.
     - Providers will need to register with this new tool to data enter original, void, or corrected professional or institutional claims for THP members. Secondary claims are also supported.

2. **View and Submit Prior Authorizations**
   Effective July 1, 2024: To comply with West Virginia prior authorization requirements, West Virginia providers participating with MHT, Commercial, and PEIA are required to submit prior authorizations through a health insurer's secure provider portal. Fax and phone prior authorization requests are not accepted from West Virginia providers.

   - Medical, Behavioral Health, and Pharmacy prior authorization lists
   - Submit inpatient and outpatient prior authorizations through THP portal and depending on the patient's plan and procedure code, practitioners will be redirected through a single sign on to GuidingCare or EviCore to complete the authorization request and upload supporting documentation and notes.
   - Status can be obtained by accessing MyPlan and clicking Manage my Authorizations under Authorizations
     - Only authorizations submitted via the portal will populate.

3. **Search Patients**
   - Access member demographic information and ID card and verify coverage, network, copays, and deductibles.

4. **Member Roster**
    - PCPs: View and download all current or previous attributed members

5. **Remittance**
    - View and download paper remittance copies

6. **Resource Library**
    - Provider Newsletters
    - Training and Education
        - Upcoming virtual education sessions and events
        - Claims submission user guides
        - Cultural Competency and Social Determinants of Health (SDoH)
        - SDoH Provider Incentive Program
    - Onboarding and Data Quality Forms
        - Credentialing
        - Practice Update
        - Practitioner Term
        - Remittance Update
    - Additional Forms
        - Specialist as PCP
        - Documentation cover sheet to support medical record submission
7. **Podcasts**
    - Podcasts exclusively for THP participating providers where THP experts discuss cyber security, system and tools, data accuracy, and more!
8. **Dual Eligible Special needs Plan Model of Care Training**
    - Medicare Advantage participating practitioners: View and attest to required training each calendar year
9. **Manage my Members**
    - Prior Authorizations
    - Disease and case management information via the Health tab
    - Member Rosters
    - Quality measures tracker
    - Hospital admission, discharge, and transfer information
    - Direct communication to THP clinical staff and patients via the Activities tab

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Chapter 2

Product Information

Provider Manual

Product Matrix

	Member selects Primary Care Physician (PCP)	Referrals required for Specialty Care	Member has open access to Specialty Care providers. *Specialists may serve as a PCP if the specialist and member eligibility is met.*	Member has open access to Behavioral/Mental Health	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 out-of-network care.	Yes, for in-network specialist physician.	YES. Refer to Directory for participating 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 out-of-network care.	Yes, for in-network specialist physician.	YES. Refer to Directory for participating providers.	YES
Fully Insured PPO	NO	NO. Member may self-refer to any network specialist to receive in-network benefits.	Yes, for in-network specialist physician.	YES. Refer to Directory for participating providers.	YES
MEDICARE ADVANTAGE					
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 out-of-network care.	Yes, for in-network specialist physician.	YES. Refer to Directory for participating providers.	NO
SecureChoice PPO	NO	NO	Yes, for in-network specialist physician.	YES. Refer to Directory for participating providers.	YES
SecureCare D-SNP	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 out-of-network care.	Yes, for in-network specialist physician.	YES. Refer to Directory for participating providers.	NO
MOUNTAIN HEALTH TRUST					
WV Medicaid Expansion/SSI/WVCHIP	YES	YES	Yes, for in-network specialist physician.	YES. Refer to Directory for participating providers.	NO
SELF-FUNDED/ASO *CONTACT THE HEALTH PLAN TO CONFIRM BENEFITS					
Self-Funded/ASO HMO, PPO, POS	PPO: NO HMO, POS: YES	PPO: NO. HMO, POS: YES. Services requiring referral/prior authorization may differ by plan sponsor.	Determined by specific employer benefits.	Determined by specific employer benefits.	Determined by specific employer benefits.
To verify eligibility or benefit information, visit the provider portal at myplan.healthplan.org.					

West Virginia Medicaid

Mountain Health Trust

Medicaid is a federal and state government program that helps with medical costs for individuals with limited incomes and resources. Mountain Health Trust (MHT) is a West Virginia managed care program established by the Bureau for Medical Services (BMS). BMS is contracted with THP for the provision of Medicaid medically necessary services for eligible West Virginia residents.

Within the MHT product are four plans:

1. **Temporary Assistance for Needy Families (TANF)** covers eligible individuals under age 19, adults that are a parent/caretaker with low or no income, and most pregnant women.
2. Under the Affordable Care Act, **Expansion (Health Bridge**) covers eligible individuals aged 19-64 with incomes up to 138% of the federal poverty level.
3. **Supplemental Security Income (SSI)** covers eligible individuals that are recipients of SSI payments and those that are aged, blind, or disabled.
4. **Children's Health Insurance Program (CHIP)** covers eligible individuals under age 19 that have incomes greater than 138% of the federal poverty level but less than 300% and pregnant women aged 19 and up that are between 185% and 300% of the federal poverty level

Commercial Fully Insured

Commercial plans are fully insured by a Health Insuring Corporation (HIC). Employers contract with THP to provide a health insurance benefit plan and pre-pay a monthly premium to cover eligible employees. Individuals employed through the state of West Virginia covered by the Public Employees Insurance Agency (PEIA) plan are included in the Commercial product.

Within the Commercial product are three plan types:

1. **Health Maintenance Organization (HMO)**
   - **West Virginia Public Employees Insurance Agency (PEIA)**
2. **Point of Service (POS)**
3. **Preferred Provider Organization (PPO)**

Medicare Advantage

Medicare is the federal health insurance program for individuals 65 years of age or older and under age 65 with certain disabilities. Medicare Advantage is a CMS approved product that provides eligible individuals additional benefits to original Medicare. THP is contracted with the Centers for Medicare and Medicaid Services (CMS) to provide healthcare services to individuals eligible for Medicare and that choose THP as their Medicare Advantage Managed Care Organization (MCO).

Within the Medicare Advantage product are three plans:

1. **SecureCare Health Maintenance Organization (HMO)** covers eligible individuals for all Part A and B services. Cost sharing and provider access differ from original Medicare.
2. **SecureCare Health Maintenance Organization (HMO) Special Needs Plan (SNP)** covers those eligible for both Medicare and Medicaid.
3. **SecureChoice Preferred Provider Organization (PPO)** covers eligible individuals for all Part A and B services. Cost sharing and provider access differ from original Medicare.

Self-Insured/Administrative Services Only

THP contracts with employer groups to offer Administrative Services Only (ASO) that include administering the employers benefit plan, processing of claims, clinical management, etc. Employer group participation includes predictable, fixed monthly payments with composite rating.

The employer groups cover the employees' medical costs that are enrolled in the Self-Funded plan and THP operates as the Third-Party Administrator (TPA) to manage the plan.

For small employers, the Multiple Employer Welfare Agreement (MEWA) includes the Chamber Benefits Plan for eligible employers domiciled in West Virginia. For eligible employers domiciled in Missouri, MEWA includes the Missouri Chamber Federation Benefit Plan.

*To learn about benefits for each plan, visit the applicable chapter:

Chapter 4 – Commercial Fully Funded and Self-Insured/Administrative Services Only

Chapter 5 – Mountain Health Trust

Chapter 6 – Medicare Advantage

TheHealthPlan

Chapter 3

Claims

Provider Manual

Claims Submission

Practitioners, Hospitals, facilities, and ancillary providers should submit claims via their clearinghouse using payer ID 95677 or through the THP MyPlan Provider Portal.
Paper claims must be submitted on red Optical Character Recognition (OCR) forms to:

The Health Plan
1110 Main Street
Wheeling, WV 26003

THP will not accept handwritten paper claim forms or paper claim forms in non-OCR format.

THP requires complete and accurate procedure and diagnosis codes on claims submission

including ICD-10 Z-codes to collect information about THP members' social determinants of health

(SDoH).

THP encourages the submission of HCPCS Category II codes to report performance measures. Using category II codes will decrease the need for THP to request medical records.

When entering the THP member ID on a claim, please include the entire member ID number with the two-digit suffix. Do not use dashes or spaces.

THP member ID numbers begin with the letter H, then eight numeric characters, and then two-numeric suffix indicates the member type.

Suffix definitions:

01 – Subscriber

02 – Spouse

03 – Child (eldest)

04 – Child (next eldest)

Timely Filing and Timely Adjudication

For THP's Commercial Fully Insured, West Virginia Mountain Health Trust (MHT) and Medicare Advantage lines of business:

- Initial claims must be submitted within180 days from the date of service.
- Corrected claims must be submitted within 180 days from the date of the original denial or within 180 days from the date of service, whichever is greater.
- Coordination of benefits (COB) claims 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).

For THP's Self Insured / Administrative Services Only customers:

- All claims must be submitted within the timely filing requirements set forth in the employer group's plan design unless otherwise required by applicable state or federal regulations.

THP will adjudicate clean claims within thirty (30) days from receipt, or as otherwise required by prompt pay requirements.

If a clean claim is not paid within the applicable timeframes, appropriate interest is applied to the claim when paid as required by state law, Medicare, or West Virginia Mountain Health Trust (MHT).

- For MHT services interest is paid to in-network providers at 18 eighteen percent (18%) per annum calculated daily for the full period the claim remains unpaid beyond the 30-day clean claims payment deadline.

THP offers Electronic Funds Transfer (EFT) at no charge for Commercial, Medicare Advantage, Mountain Health Trust (WV Medicaid & CHIP), & PEIA.

To enroll with THP's EFT, access THP's secure provider portal resource library and complete the 'EDI & EFT Enrollment Form.'

Self-funded/ Administrative Services Only (ASO) EFT will process through vendor, VPay. VPay's default payment method is virtual credit card. Providers can update their VPay payment method by contacting VPay at 1.877.714.3222.

Provider Overpayments

THP is responsible to recovery all overpayments, including those due to fraud, waste, and abuse.

In the event 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.

Providers are required to notify THP in writing of self-identified overpayment and return the full amount to THP within sixty (60) calendar days of when the overpayment was identified.

Provider Reconsideration (Appeal)

If a provider does not agree with a THP claim denial, then the provider has the right to file a reconsideration (appeal).

THP's Provider Reconsideration is a one-level appeal. A provider has the greater of 180 days from THP's original denial or 180 days from the date of service to request a reconsideration (appeal).

To file a provider reconsideration (appeal), provider can call 1.877.847.7901 or mail:

The Health Plan
Attn: Appeals
1110 Main Street
Wheeling, WV 26003

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 because of duplicate group health care coverage.

Commercial Fully Insured and ASO

Each employer group contracting with THP has a COB provision in their contract. In accordance with your provider contract, claims for THP members with another insurance should be submitted to the primary carrier first for payment.

- Primary plan – plan that reviews for payment first
- Secondary plan – plan that reviews for payment second

When THP is the secondary payer, THP will adjudicate the balance of covered services not paid by the primary plan, so long as the total payment does not exceed one-hundred percent (100%) of your contracted rates.

National Association of Insurance Commissioners (NAIC) COB Calculation

Some Commercial Fully Insured and ASO customers 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.

West Virginia Mountain Health Trust Members

For MHT 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, up to the allowed WV Medicaid or CHIP limit. If THP is responsible for West Virginia MHT, including WV Medicaid, 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.

COB and Benefit Order 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 THP is primary.)
- **Spouse:** The plan covering that person as a dependent pays benefit second. (If the patient is the spouse of our subscriber, THP 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.

COB Billing

- 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 include the primary explanation of benefits (EOB)
  - 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 THP as secondary.

COB Denials

Each COB claim is reviewed to determine whether THP is primary. If you receive a COB denial (listed below), please submit correct information, if applicable, based on the denial.

- For COB questions contact the COB Department at 1-800.624.6961, ext. 7903.

CARC/RARC	Description
D251/RN4820	Incomplete/invalid Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).
D89	Patient is enrolled in Hospice.
D19	This is a work-related injury/illness and thus liability of the Worker's Compensation Carrier.
D16/RN479	Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).
D16/RN4	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.

Members with Double THP Coverage

- Bill the copay, deductible, and/or co-insurance shown on the payment remittance by using the member's secondary ID number.
- Attach a copy of the remittance showing THP's payment.

Original Medicare Primary

Any provider who has submitted an assigned claim to Original Medicare has agreed to accept Medicare's reasonable charge as payment in full for their services. Per the Medicare's Carriers Manual, section 3045.1, the provider is in violation of their signed agreement if they bill or collect from the enrollee and/or the private insurer an amount which, when added to the Medicare benefit received, exceeds the reasonable charge.

THP, as a Medicare supplemental insurer, is functioning as a private insurer. Therefore, THP will be reimbursing the physician for THP covered services when that reimbursement amount does not exceed THP's standard reimbursement.

THP 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 THP would pay as the primary carrier. This process is applied to each individual service.

Original Medicare Members

Below are steps to follow when billing for a Medicare member:

1. **REGULAR MEDICARE (red, white, and blue card):** THP 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 THP 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 THP 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 THP 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 a Medicare Supplement ID card from THP, you will no longer have to submit a claim to THP after Medicare pays.
- Medicare will send us your claim information and we will then process for the remaining copayment, co-insurance, or deductible.
- THP will only cover those services that have been allowed or paid by Medicare. If Medicare denies the service, THP will also deny your claim.

Medicare Primary Payment Example

THP Employer Group Coverage Secondary

BILLED AMOUNT	140.00
MEDICARE ALLOWABLE	81.90
MEDICARE PAYMENT	65.52
MEDICARE CO-INSURANCE	16.38
THP PAYMENT	16.38

Medicare Primary Payment as Displayed on Remittance

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)									

Documentation Submission

THP has a dedicated fax line to submit documentation, 740.699.6163.

To assure documentation is routed correctly, please complete THP's documentation cover sheet in its entirety. A copy of the cover sheet is available on THP's provider portal, myplan.healthplan.org. Failure to complete the cover sheet may result in claim denials. A separate cover sheet is required for each claim.

All required documentation must be faxed within twenty-four (24) hours of your electronic claims transmission.

Never Events and Avoidable Hospital Conditions

Never Events

According to the National Quality Forum (NQF), never events are errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and that indicate a real problem in the safety and credibility of a healthcare facility. Never events consist of the wrong procedure being performed on the wrong body part, and/or wrong site, or on the wrong patient. 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 THP does receive claim(s) for such services, these are appropriately denied for lack of medical necessity.

Avoidable Hospital Conditions

Avoidable hospital conditions (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
- Iatrogenic pneumothorax with venous catheterization
- 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
- Surgical site infection following cardiac implantable device (CEID)
- Surgical site infection following certain orthopedic procedures
- Vascular catheter-associated infection and surgical site infection

CMS requires that, effective October 1, 2007, hospitals must submit 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.

THP 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 for review. 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 THP. Any of the diagnoses or conditions clearly documented as present upon an inpatient admission are not preventable by CMS guidelines.

Notice of Readmissions Review Occurring Within 30 Days

All clinically related /potentially preventable readmissions occurring within a thirty (30) day period are subject to review. Final review decisions are made by a THP medical director. Readmissions are denied when any of the following are determined:

- If the readmission was medically unnecessary
- If the readmission resulted from a prior premature discharge from the same hospital,
- If the readmission resulted from a failure to have proper and adequate discharge planning OR
- If the readmission resulted from a failure to have proper coordination between the inpatient and outpatient healthcare teams and/or if the readmission was the result of circumvention of the contracted rate by the hospital

Physicians and practitioners should follow these guidelines:

- Hospital readmissions within thirty (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.
- The index admission date should be reported.
- Combine the appropriate number of observation and inpatient days for the index admission and the readmission.
- Enter 180 (or the appropriate leave code) and appropriate service units to account for the days between the admission and the readmission when the member was not receiving services. $0.00 should appear in "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.

Remittance

The payment remittance contain three sections:

- Claims paid by line of business
- Claims denied by line of business
- Claims in process

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Chapter 4

Commercial Fully Insured and Self-Insured/ Administrative Services Only

Provider Manual

Commercial Health Maintenance Organization (HMO) Plans

Commercial health maintenance organization (HMO) plans are fully insured by a Health Insuring Corporation (HIC). Employer groups contract with THP and pay a monthly premium to provide a health insurance benefit plan to eligible employees. THP 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 provider (PCP), obtain a referral from their chosen PCP and follow all prior authorization guidelines. Members do not have out-of-network benefits unless authorized by the plan.

HMO benefit plans generally have copays for:

- Primary and specialty care practitioner 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 (2) employees, contract with THP and pay a monthly premium to provide a health insurance benefit plan to 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 practitioner 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 THP 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 practitioner office visits
- Emergency room services
- Urgent care
- Outpatient mental health
- Physical, occupational, and speech therapy
- Durable medical equipment
- BioTech drugs

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). Members who are covered under the PPO plan generally are not required to select a primary care provider (PCP) or obtain a referral for specialty practitioner services. All prior authorization guidelines apply. By utilizing THP's network, members receive a higher level of benefits. Members who utilize out-of-network providers or fail to prior authorize 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 practitioner office visits
- Emergency room services
- Urgent care
- Outpatient mental health benefits
- Physical, occupational, and speech therapy
- Durable medical equipment
- BioTech drugs

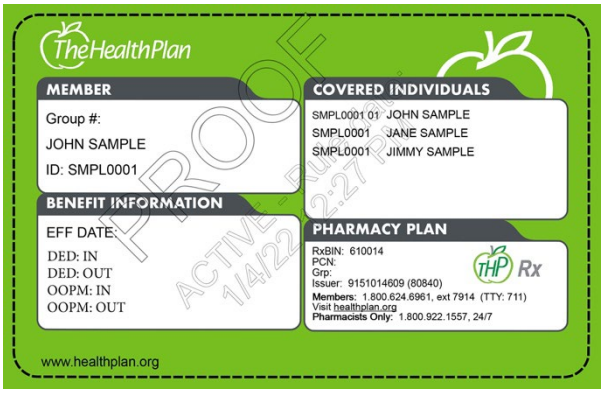
Members are responsible for deductibles and co-insurance amounts associated with their benefit plan.

Sample Commercial Member ID Cards

This card is issued to members enrolled in a Commercial (including Health Maintenance Organization [HMO], Preferred Provider Option [PPO] and Point of Service [POS]) plan. This includes WV State employees who are covered by the Public Employees Insurance Agency (PEIA) plan.

Commercial WV Sample ID Card

FRONT



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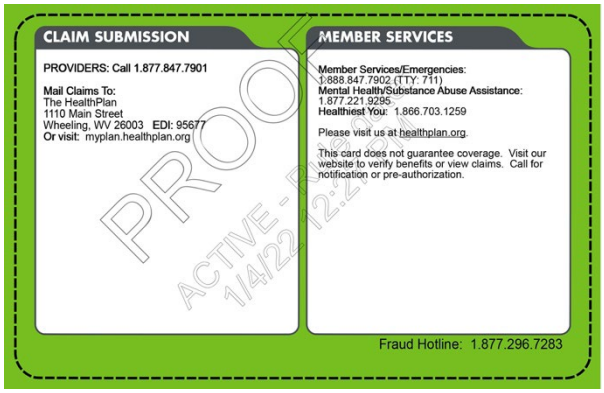

Commercial Ohio Sample ID Card

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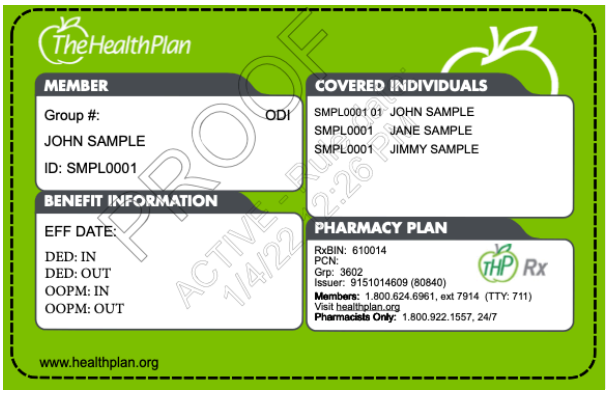

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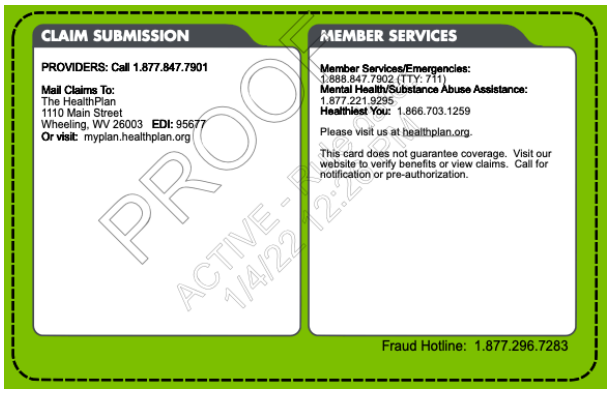

Self-Funded / Administrative Services Only (ASO) Employer Groups

Employers may choose to pay claims as they are incurred, rather than pay a monthly premium for their employee's medical benefits. THP 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 THP. ASO plan benefits, copays, deductibles, and ID cards may vary from the standard insured plans offered by THP.

Sample Self-Funded/ASO ID Cards

This card is issued to members who are enrolled in a Self-Funded plan. The employer's name will differ on these cards (as shown on the front of the card).

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

Self-Funded/ASO Sample ID Card

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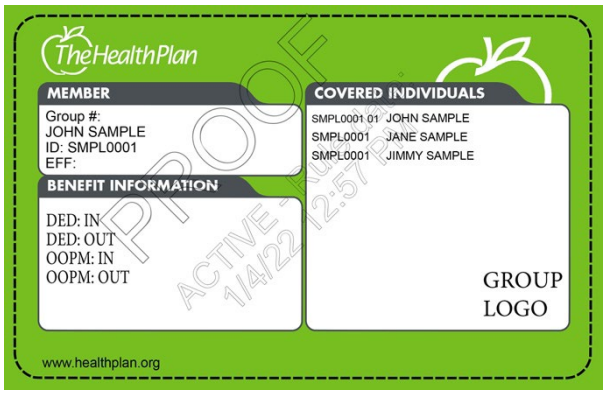

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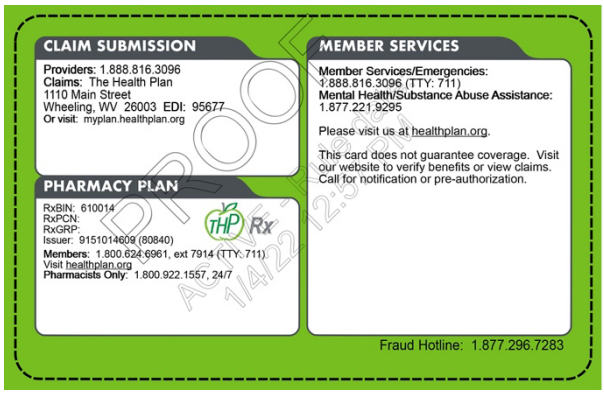

Self-Funded/ASO Reference Based Pricing (RBP) Sample ID Card

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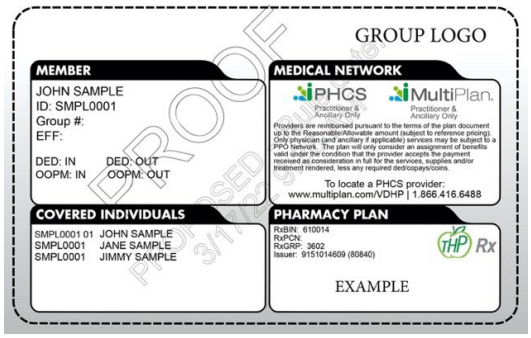

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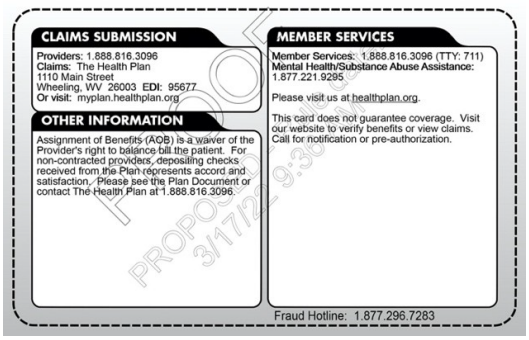


Vision Service Benefits

Members enrolled through THP Commercial programs may also have vision benefits. Superior Vision administers vision benefits for Commercial members. Please contact Superior Vision for information on benefits and coverage under these vision plans.

THP offers benefit riders for vision benefits administered through Superior Vision for Commercial members. Providers must be participating with Superior Vision before offering covered vision services to members.

Supervisor Vision can be contacted at https://superiorvision.com/contact/

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 and credentialed ophthalmologist or optometrist with THP. A referral from the primary care provider (PCP) may be required for the member to obtain medical services from an ophthalmologist or optometrist.

Vision Billing

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 THP's vision benefit vendors, provided you are a participating provider.

The visit should billed to THP as an 837p (professional) claim with the following codes:

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

After THP 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 THP's vision provider (if you are a participating provider) for payment of the refraction.

Please include THP's payment remittance when submitting to Superior Vision for the remaining portion.

Superior Vision will coordinate benefits with THP 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 THP, you may also submit a claim for the refraction to that plan and they will adjudicate the claim according to their plan guidelines.

- THP 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 office copayment is waived.

THP'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 THP'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 THP member's medical history and enrollment file is confidential. The member has a right to approve or refuse the release of personal information by THP except when the release is required by law. THP assures that all patient information is held in the strictest confidence. All staff must adhere to THP 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 provider (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 THP are encouraged to establish a relationship with their chosen PCP so that they can work together to maintain good health. Members of THP may change practitioners once per calendar month if so desired (depending upon the availability of the chosen practitioner).
- THP members have the right to express their comments, opinions or complaints about THP or the care provided and to file a grievance for an administrative or medical complaint and hearing procedures without reprisal from THP. Members also have the right to have coverage denials reviewed by the appropriate medical professionals consistent with THP review procedures. Both informal and formal steps are available to members to resolve all complaints/grievances.
- THP 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.
- THP 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 THP through yearly member satisfaction surveys, telephone calls from our members, by email to: information@healthplan.org or through our corporate website, healthplan.org. Member's comments/opinions are also received through various departments at THP.

- 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 THP Customer Service Department at 1.888.847.7902.

Statement of Members' Responsibilities

- A member must choose a PCP for each person listed on THP ID card. The member has a responsibility to maintain a relationship with a PCP, as the PCP will act as the coordinator for all their health care needs.
- A member must identify themself as a member of THP 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 THP for assistance, if necessary.
- A member is required to notify THP 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 PCP
- Members are asked to be on time for appointments and to call the practitioner's office promptly if an appointment cannot be kept.
- Members must provide necessary information to the practitioners 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 THP's service area, they are required to contact THP as soon as possible within 48 hours.
- Members must contact their PCP, secondary care practitioner, or OB/GYN before seeking any specialty practitioner/service.
- Members must provide THP with all relevant, correct information and pay THP 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 THP employees, providers, and their THP member handbook is the primary source of information regarding THP member benefits.

THP member handbook is available upon request by the member.

Member Copayments, Co-insurance & Deductibles

THP offers benefit plans requiring member responsibility 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, and deductibles. As groups re-enroll annually, the member copayment may change, depending upon the plan selected by the employer. A provider should not collect more than the amount that is the member's responsibility as a copayment, coinsurance and/or deductible.

Copayments

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 THP ID cards are shown on the product matrix located in **Chapter 2 – Product Information**.

Member copayments for practitioner office visits and certain other services can be found on THP's provider secure portal at myplan.healthplan.org

Copays may not be waived; this is a provider's contract violation.

Copays do not apply to hospital inpatient practitioner visits, preventive services, and/or prenatal office visits (after the initial visit), practitioner 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.

Collecting copayments when another insurance is primary

If you have questions regarding whether to collect an office copay, please contact THP Coordination of Benefits Department at 1.800.624.6961, ext. 7903, or refer to the secure provider portal's 'Search Patients' tool at myplan.healthplan.org.

Co-insurance

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 determine the member's specific benefit and apply any contract reimbursement terms to determine the amount of the co-insurance.

THP suggests providers wait until payment remittance is received where member responsibility is indicated. A copy of the remittance is 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 to determine how much of the annual deductible has been met at a certain point in time.

Affordable Care Act and Member Responsibility

The Affordable Care Act (ACA) requires private insurers to cover certain preventive services without any patient cost-sharing. THP products affected by the ACA are 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 members 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 plan states otherwise.

At no time should a provider collect more than the amount that is the member's responsibility as a copayment, coinsurance and/or deductible.

TheHealthPlan

Chapter 5

Mountain Health Trust (MHT)

Provider Manual

Mountain Health Trust (MHT) Program

The Mountain Health Trust (MHT) program includes West Virginia (WV) Medicaid which includes: Temporary Assistance for Needy Families (TANF), Expansion, and Supplemental Security (SSI), the West Virginia Children's Health Insurance Program (WVCHIP) membership.

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

THP will notify providers at least thirty (30) days in advance of WV Bureau of Medical Services (BMS)

and/or MHT program changes.

Mountain Health Trust Member ID Cards and Member Eligibility

The member is expected to present both their THP card and Medicaid card (8.5"x11" eligibility form) when receiving services. Each eligible individual family member will have a separate ID card with their own plan ID number. The THP member ID card has the applicable program logo and important information including:

- Member's plan ID # including – 01 suffix (the "H" and suffix must be included when submitting claims)
- Department of Human Services (DoHS) assigned member ID number
- Member's name
- Member's Primary Care Physician (PCP) name
- PCP phone number

All members, except newborns, become effective on the first of each month and become terminated on the last day of the month. To verify member eligibility please visit THP's secure provider portal or call the Customer Service Department at 1.888.613.8385. Providers may also use the State's MMIS Portal to validate eligibility. If you do not have access to THP's provider portal, please contact Provider Data Quality (PDQ): pdq@healthplan.org

When medically necessary, practitioners are required to make services available 24 hours a day, seven days a week. Physicians must comply with the access standards set forth in **Chapter 10 - Quality** of the provider manual.

THP must cover a member's out-of-network services covered under the Mountain Health Trust if THP's provider network is unable to provide those services. THP will ensure the member's cost is no greater than if the services were rendered within THP's provider network. Out-of-network services must be covered as adequately and as timely as if those services were provided within THP's provider network, and for as long as the THP provider network is unable to provide the service.

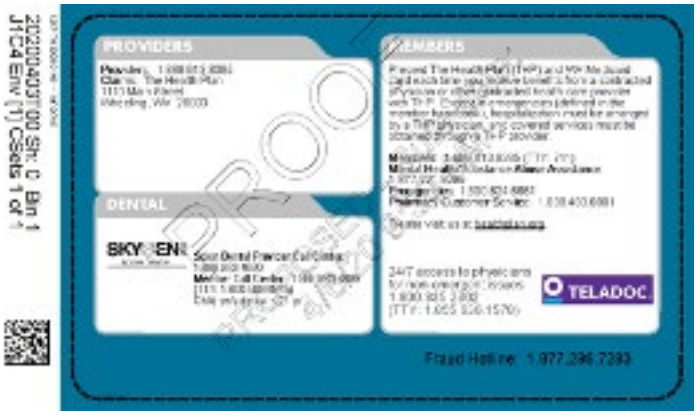
THP must ensure that services are provided in a culturally competent manner to all members, including those with limited English proficiency and/or limited reading skills, those with diverse cultural and ethnic backgrounds, the homeless, and individuals with physical and mental disabilities, regardless of gender, sexual orientation, or gender identity. THP also ensures the THP provider network offers MHT members with physical and/or mental disabilities physical access, reasonable accommodations for physical access, and accessible equipment.

Mountain Health Trust Member ID Cards

THP Medicaid member ID cards are color-coded blue to more easily identify THP's Medicaid population. If you have any questions, please contact our Customer Service Department at 1.888.613.8385.

WV Medicaid

Group number: 0140, 0141 and 0142



WVCHIP ID Card

THP WVCHIP cards are color-coded light blue to more easily identify the WVCHIP population. If you have any questions, please contact THP Customer Service Department at 1.888.613.8385.

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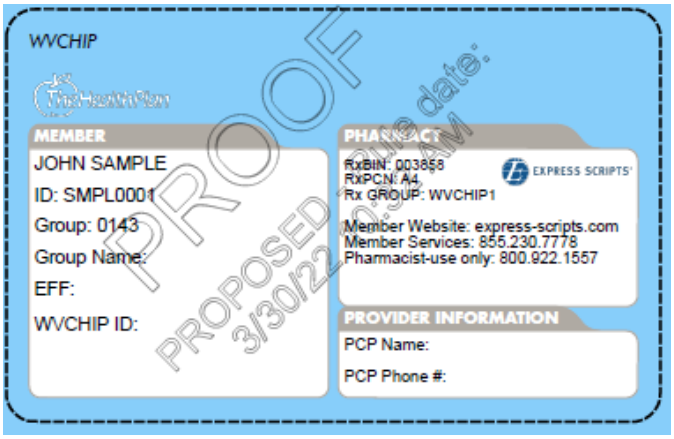

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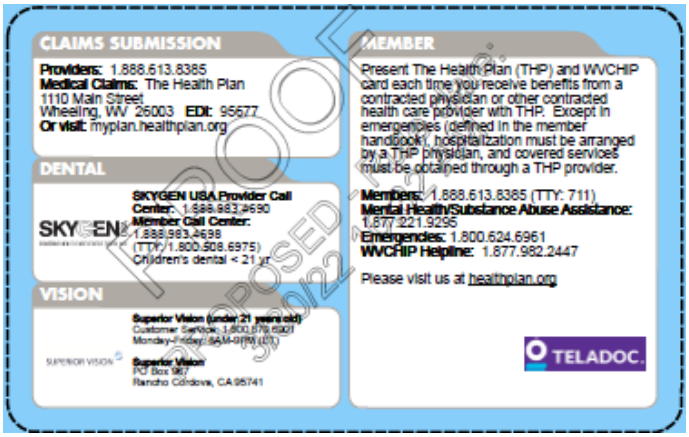


Medicaid Benefits and Exclusions at a Glance

Benefit packages differ, depending on the member's age and whether the member is covered under Mountain Health Trust.

Mountain Health Trust 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 use disorder (SUD) 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 0-20, Requires prior authorization. Limits apply.

Hospital

- **Inpatient**– Includes all inpatient services (including bariatric, long term acute care (LTAC) and corneal transplants). Transplant services must be in a center approved by Medicare and Medicaid and covered under fee-for-service. 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. Limited to 3 sessions per week for 12 weeks or 36 visits per 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). Requires prior authorization.
- **Physical Therapy -** Twenty (20) visits per year for habilitative and rehabilitative services (combined for physical and occupational therapy).
- **Occupational Therapy -** Twenty (20) visits per year for habilitative and rehabilitative services (combined for physical and occupational therapy).
- **Speech Therapy -** Habilitative and rehabilitative services including hearing aid evaluations, hearing aids and supplies, batteries, and repairs (for children under age twenty-one (21). Some procedures have service limits or need prior approval.
- **Chiropractor Services -** Includes radiological exams and corrections to subluxation. Certain procedures has service limits.

Mountain Health Trust 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. Select procedures require prior authorization. Consult with your doctor before receiving services.
- **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 0-20) 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. The Health Plan has certified American Lung Association Freedom from Smoking counselors to help you quit smoking. Most people already know that smoking is bad for their health. Our program focuses on how to quit, not why. Freedom From Smoking is designed to help tobacco users get control of and break their addiction. No one method works for all tobacco users. The Health Plan's program is 90 days. A counselor will call you and help you get any prescriptions approved. They will help you build better habits and break current ones. People who finish the program are six times more likely to be tobacco free one year later than those that quit on their own. If you would like to quit give our counselors a call at 1-888-450-6023.
- **Sexually Transmitted Disease Services—** Includes screening for a sexually transmitted disease from your PCP or a specialist in our network.
- **Preventive Screenings—** Annual pap smear for cervical cancer screening beginning at age 18, earlier if medical 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.

Mountain Health Trust Covered Benefits

Maternity

- **Right From The Start—**Includes prenatal care and care coordination. Services covered through 12-month postpartum 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. **Sterilizations are not covered for enrollees under age twenty-one (21), for enrollees in institutions, or for those who are mentally incompetent. Services may be accessed by in network or out of network providers.**
- **Maternity Care—**Includes prenatal, inpatient hospital stays during delivery, and postpartum care. Home birth is not covered.

Durable Medical Equipment, Orthotics and Prosthetics

- **Devices and medical equipment prescribed by a physician to ameliorate disease, illness, or injury. Certain procedures have services limits or need prior authorization. Customized special equipment considered.**
- Requires pre-authorization and must meet The Health Plan guidelines.
- Limited replacements.
- Other limitations may apply.

Hospice

Requires prior authorization for all visits. If you revokes three times,you are 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. Pre-authorization required prior to 2nd certification period.

Dental

- **For children (ages 0-20)**
  - Must use participating practitioners (see provider directory or call Skygen Dental, **1.888.983.4698**).
  - 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, **1.888.983.4698**).
  - Accident or injury, tumor removal, or emergency extraction
  - $2,000 benefit for preventive and restorative care, such as cleanings and crowns, every two years
  - TMJ is not covered for adults.

Mountain Health Trust Covered Benefits
Vision • **For children (ages 0–20)** o Must use participating vision services practitioners. See provider directory or call Superior Vision. o Vision screening and therapy. o One eye exam covered once every 12 months. o Limited one frame per year. o Contact lenses covered for certain diagnoses. o Repairs. • **For adults (21 and older)** o Adults limited to medical treatment only. o Medical contact lenses for adults and children covered for certain diagnoses. o 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.

Mountain Health Trust Covered Benefits

Hearing

- **For children (ages 0–20)**
  - Audiology screening/testing does not require authorization (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 or devices 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 for functional testing **for specific medical conditions**.
  - Hearing aid evaluations, hearing aid supplies, batteries, and repairs are not covered for members aged 21 and older.

Behavioral Health

- **Behavioral Health Rehabilitation/Psychiatric Residential Treatment Facility –** Includes services for children (age 20 and under) with mental illness and substance abuse. Limits frequency and amount of services. Certain services require pre-authorization.
- **Inpatient Psychiatric Services –** Includes treatment through an individual plan of care including post-discharge plans for aftercare. Service is expected to improve the condition or prevent regression so the service will no longer be needed.
  - **Under age 21** - Includes services at a psychiatric hospital or psychiatric unit of a hospital. Certification required. Pre-admission and continued stay prior authorization is required.
  - **Age 21 to 64** - Includes treatment at an Institution for Mental Diseases (IMD).
- **Outpatient –** Includes services for individuals with mental illness and substance abuse. Limits frequency and amount of services. Providers must be ACT certified. Children's residential treatment is not covered. Certain services require pre-authorization.
- **Psychological Services–** May be delivered using telehealth. Some evaluation and testing procedures have frequency restrictions. Certain services require pre-authorization.
- **Drug Screening –** Laboratory services to screen for presence of one or more drugs of use. Limits apply and pre-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 abuse. Prior authorization is required.

Gender Affirmation Surgery

- Procedure that aligns an individual's biological sex with their gender identity. Adults must be twenty-one (21) years or older prior to being considered for the procedure. Prior authorization is required.

Benefits Under Fee-for-Service Medicaid
Abortion – Includes drugs or devices to prevent implantation of the fertilized ovum and procedures for termination of ectopic pregnancy. Physician certification required. All Federal and State laws regarding this benefit apply.
Early Intervention Services for Children Three and Under – Includes services and supports provided through the West Virginia Birth to Three program for children under age three (3) who have a delay in their development, or may be at risk of having a delay, and for their families.
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 persons with a developmental disability. Requires physician or psychiatrist certification.
Prescription Drugs –Includes dispensed drugs on an ambulatory basis by a pharmacy, family planning supplies, diabetic supplies, vitamins for children, and prenatal vitamins. Not covered: Drugs for weight gain/ loss, cosmetic purposes, hair growth, fertility, less than effective drugs and experimental drugs. Call the WVMMIS HelpDesk at 1-888-483-0797 to help you find a pharmacy or to find out if your pharmacy is in network. *You can also find this information at wvmmis.com. You can access the WV Medicaid Preferred Drug List (PDL) by visiting: https://dhhr.wv.gov/bms/BMS%20Pharmacy/Pages/Preferred-Drug-List.aspx *Please note, the PDL is subject to regular updates by the WV Medicaid program. The Health Plan will still cover some drugs. We cover medicines that you get during a hospital stay and in the emergency room. We also cover those you get in the doctor's office, such as injectable medicines like vaccines. Drugs, drug products and related services, which are defined by the Bureau for Medical Services' Outpatient Drug Pharmacy Program as a non-covered benefit will not be covered by The Health Plan. Hemophilia blood factors and hepatitis C virus related drugs are covered by traditional Medicaid.
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 – Services provided by a physical therapist, speech therapist, occupational therapist, nursing care agency, or audiologist in a school-based setting. Limited to individuals under age twenty-one (21). Service limitations are listed in the fee for service Medicaid policy manual.
Transportation – WV Medicaid covers non-emergent medical transportation through a third-party vendor (ModivCare). Members may call 1-844-549-8353 to schedule a trip. Routine transport is required to be scheduled at least 5 business days in advance of your appointment. You may also receive gas mileage reimbursement if you provide self-transport or receive transportation from a friend or family member. ModivCare will provide you with a mileage reimbursement trip log to return to them with your appointment information.
Opioid Treatment Program – Services under the SUD 1115 Waiver Comprehensive opioid MAT program including medication, treatment services and laboratory services.

Mountain Health Trust (WV CHIP) Covered Benefits

Mountain Health Trust (WV CHIP) 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 use disorder (SUD) treatment. Services must be ordered by a physician and certain procedures have service limits. Genetic testing requires pre-authorization. • **Clinics**—Includes general clinics, birthing centers, and health department clinics. Vaccinations are included for children. • **Private Duty Nursing**—For children ages 0-20. Requires prior authorization limits apply. • **Vaccinations** - Vaccinations are included for children and as approved for adults.
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. Requires prior authorization. • **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. Limited to 3 sessions per week for 12 weeks or 36 sessions per 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 pre-authorization. • Physical Therapy. Twenty (20) visits per year for habilitative and rehabilitative services (combined for physical and occupational therapy). • Occupational Therapy. Twenty (20) visits per year for habilitative and rehabilitative services (combined for physical and occupational therapy).

- Speech Therapy. Habilitative and rehabilitative services including hearing aid evaluations, hearing aids and supplies, batteries, and repairs (for children under age twenty-one (21). Some procedures have service limits or need prior approval.
- Chiropractor Services. Includes radiological exams and corrections to subluxation. Certain procedures has service limits.

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. Select procedures require prior authorization. Consult with your doctor before receiving services.
- **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 pre-authorization.

Preventive Care and Disease Management

- **EPSDT**—(ages 0-20) 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 a pre-authorization.
- **Tobacco Cessation**—Includes therapy, counseling, and services. Guidance and risk-reduction counseling covered for children. The Health Plan has certified American Lung Association Freedom from Smoking counselors to help you quit smoking. Most people already know that smoking is bad for their health. Our program focuses on how to *quit*, not *why*. Freedom From Smoking is designed to help tobacco users get control of and break their addiction. No one method works for all tobacco users. The Health Plan's program is 90 days. A counselor will call you and help you get any prescriptions approved. They will help you build better habits and break current ones. People who finish the program are six times more likely to be tobacco free one year later than those that quit on their own. If you would like to quit give our counselors a call at 1-888-450-6023.
- **Sexually Transmitted Disease Services**—Includes screening for a sexually transmitted disease from your PCP or a specialist in our network.
- **Preventive Screenings**—Annual pap smear for cervical cancer screening beginning at age 18, earlier if medical 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 12-months 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. **Sterilizations are not covered for enrollees under age twenty-one (21), for enrollees**

in institutions, or for those who are mentally incompetent. Services may be accessed by in network or out of network providers.

- **Maternity Care—**Includes prenatal, inpatient hospital stays during delivery, and post-partum care. Home birth is not covered.

Durable Medical Equipment, Orthotics, and Prosthetics

- Devices and medical equipment prescribed by a physician to ameliorate disease, illness, or injury. Certain procedures have services limits or need prior authorization. Customized special equipment considered.
- Requires pre-authorization and must meet The Health Plan guidelines.
- Limited replacements.
- Other limitations may apply.

Hospice

- Requires pre-authorization for all visits. If you revoke three times, you are 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. **Pre-authorization required to 2nd certification period.**

Dental

For children (ages 0-20)

- Must use participating practitioners (see provider directory or call Skygen Dental at **1-888-983-4698**).
- Orthodontics covered for the entire duration of treatment regardless of loss of eligibility. Requires pre-authorization.

For adults (21 and older)

- Must use participating practitioners (see provider directory or call Skygen Dental at **1-888-983-4698**).
- Accident or injury, tumor removal, or emergency extraction.
- $2,000 for preventive and restorative care, such as cleanings and crowns, every two (2) years.
- TMJ is not covered for adults.

Vision

For children (ages 0–20)

- 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 diagnosis.
- Repairs.

For adults (21 and older)

- Adults limited to medical treatment only.
- Medical contact lenses for adults and children covered for certain diagnosis.
- One pair of glasses up to 60 calendar 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 reveal abnormal conditions, any follow-up appointment with a specialist will require pre-authorization from the member's PCP.

Hearing

For children (ages 0–20)

- Audiology screening/testing does not require authorization (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 or devices may have service limits or require prior authorization. Augmentation communication devices are limited to children under 21 years of age and require prior approval.

For adults (21 and older)

- Requires pre-authorization for functional testing **for specific medical conditions.**
- Hearing aid evaluations, hearing aid supplies, batteries, and repairs are not covered for members aged 21 and older.

Behavioral Health

- **Behavioral Health Rehabilitation/Psychiatric Residential Treatment Facility** – Includes services for children (age 20 and under) with mental illness and substance abuse. Limits frequency and amount of services. Certain services require pre-authorization.
- **Inpatient Psychiatric Services –** Includes treatment through an individual plan of care including post-discharge plans for aftercare. Service is expected to improve the condition or prevent regression so the service will no longer be needed.
    - **Under age 21** – Includes services at a psychiatric hospital or psychiatric unit of a hospital. Certification required. Pre-admission and continued stay prior authorization is required.
    - **Ages 21 to 64** – Includes treatment at an Institution for Mental Diseases (IMD).
- **Outpatient** – Includes services for individuals with mental illness and substance abuse. Limits frequency and amount of services. Providers must be ACT certified. Children's residential treatment is not covered. Certain services require pre-authorization.
- **Psychological Services** – May be delivered using telehealth. Some evaluation and testing procedures have frequency restrictions. Certain services require pre-authorization.
- **Drug Screening** – Laboratory services to screen for presence of one of more drugs of use. Limits apply and pre-authorization is required for some testing.
- **Substance Abuse Disorder (SUD) Services –** Targeted case management, residential services, peer recovery support services and counseling services to treat those with substance abuse. Prior authorization is required.

Benefits Under Fee-for-Service WVCHIP
Abortion – Includes drugs or devices to prevent implantation of the fertilized ovum and procedures for termination of ectopic pregnancy. Physician certification required. All Federal and State laws regarding this benefit apply.
Early Intervention Services for Children Three and Under – Includes services and supports provided through the West Virginia Birth to Three program for children under age three (3) who have a delay in their development, or may be at risk of having a delay, and for their families.
Tubal Ligation – Family planning service for individuals of childbearing age to permanently prevent pregnancy. Service requires informed consent and medical necessity.
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.
Prescription Drugs – Includes dispensed drugs on an ambulatory basis by a pharmacy, family planning supplies, diabetic supplies, vitamins for children, and prenatal vitamins. Not covered: Drugs for weight gain/loss, cosmetic purposes, hair growth, fertility, less than effective drugs and experimental drugs. Call the WVMMIS HelpDesk at 1-888-483-0797 to help you find a pharmacy or to find out if your pharmacy is in network. *You can also find this information at **wvmmis.com**. The Health Plan will still cover some drugs. We cover medicines that you get during a hospital stay and in the emergency room. We also cover those you get in the doctor's office, such as injectable medicines like vaccines. Drugs, drug products and related services, which are defined by the Bureau for Medical Services' Outpatient Drug Pharmacy Program as a non-covered benefit will not be covered by The Health Plan. Hemophilia blood factors and hepatitis C virus related drugs are covered by WVCHIP FFS
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.
Transportation – WVCHIP covers non-emergent medical transportation through a third-party vendor (ModivCare). Members may call 1-844-549-8353 to schedule a trip. Routine transport is required to be scheduled at least 5 business days in advance of your appointment. You may also receive gas mileage reimbursement if you provide self-transport or receive transportation from a friend or family member. ModivCare will provide you with a mileage reimbursement trip log to return to them with your appointment information.
Opioid Treatment Program – Services under the SUD 1115 Waiver Comprehensive opioid MAT program including medication, treatment services and laboratory services.

MHT Benefit Exclusions

Some services are not available through THP or Medicaid/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:

- All non-medically necessary services.
- Services from non-enrolled or non-participating providers.
- Services that require a prior authorization, but did not get a prior authorization.
- Sterilization of a mentally incompetent or institutionalized individual.
- Except in an emergency, inpatient hospital tests that are not ordered by the attending physician or other licensed practitioner, acting within the scope of practice, who is responsible for the diagnosis or treatment of a particular patient's condition.
- Treatment for infertility and the reversal of sterilization.
- All cosmetic services, except in the case of accidents or birth defects.
- Christian science nurses and sanitariums.

*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. If you have a question about whether a service is covered, please call 1-888-613-8385.

Additional Resources for Mountain Health Trust Members

Program	Description	MHT Population	Contact Information
Tobacco Cessation	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. The program addresses: • 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
Non-Emergent Transportation	• Members with Medicaid or WVCHIP may be eligible for transportation services • Members can contact NEMT broker to schedule a reservation	All	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 Department of Human Services, 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
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)

Practitioner Hours of Operation

Practitioners must ensure hours of operation for members' care are convenient, do not discriminate against members, and are no less than the hours of operation offered to commercial members or to Medicaid fee for service. Practitioners must ensure that waiting time to be seen is minimal and that the MHT member waiting time standard is the same wait time standard for commercial members. Practitioners cannot discriminate against MHT members in the order that patients are seen, or in the order that appointments are given (meaning, practitioners are not permitted to schedule "Medicaid-only" days).

Cultural Competency, Implicit Bias, and Social Determinants of Health (SDoH)

Mountain Health Trust (WV Medicaid and WVCHIP) providers are required to perform healthcare services in a culturally competent manner to all members. This includes members with limited English proficiency and/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 developed cultural competency and social determinants of health (SDoH) provider education. THP's Cultural Competency/Social Determinants of Health Training is available on THP's provider portal Resource Library. THP's Practice Management Consultants (PMC) will discuss this cultural competency training during meetings with your office and are available for individualized education sessions. To request a training session, please contact your PMC.

Practice Training Guidelines

Providers should develop training program(s) for staff inclusive, but not limited to, member needs that can help with addressing physical, behavioral and environmental health i.e., Adverse Childhood Experiences (ACEs) and Motivational Interviewing.

THP can provide training materials on these topics, upon request.

Information regarding THP's clinical guidelines and policies is available at the following links:
https://www.healthplan.org/providers/resources/policies/medical-policies
https://www.healthplan.org/providers/resources/policies/payment-policies
https://www.healthplan.org/providers/prior-authorization-referrals/forms-prior-auth-list-notices

*Lists are not all-inclusive and updated based on provider feedback.

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 perform the screening (periodic, comprehensive child health assessments) for all eligible members.

EPSDT services 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 to document all the above on the member's chart or electronic health record (EHR) as well as referrals. The provider should submit an 837P or 1500 claim form with the appropriate diagnosis codes, and procedure codes and modifiers. **The EP modifier must be billed on all EPSDT services.**

EPSDT claims are paid without any coordination of benefits. Further information including current EPSDT forms and periodicity guidelines is available at:

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

If the provider performs a well-child exam at the same time as a sick visit, please use the appropriate diagnosis, procedure, and modifier codes.

THP members receive a reminder notice that a well-child exam is due.

Medicaid Copays

Medicaid members have copays for select 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

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 12-month postpartum
- 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.

For prescribers issuing controlled substances, prescribers must review the WV PDMP in accordance with Section 5042 of the SUPPORT Act. In the case that a prescriber is not able to check the PDMP despite a good faith effort by the prescriber, the prescriber must document such good faith effort, including the reason(s) why the prescriber was not able to check the PDMP. Prescribers may be required to submit, upon request, such documentation to Medicaid.

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 19 years of age or older.**

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 Provider 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 PCP office visits.

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 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.

Mountain Health Trust Out-of-Network Non-Patient Facing Provider Reimbursement and Emergency 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. Providers may not balance bill enrollees for covered services. More specifically, a participating provider cannot bill for the difference between the provider's charge and the allowed amount. Providers must be in compliance with Section 1902(n)(3)(B) of the Social Security Act, A and Section 1417 of the Balanced Budget Act of 1997. 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 existed.
THP 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 THP.

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 are defined as those services provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy.

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 that family planning provider's THP participation status.

Family planning 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

THP contracts with West Virginia Health Departments to provide certain MHT services 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's pediatric members with elevated blood levels will be reimbursed directly by the State Bureau for Public Health. THP is responsible for reimbursing those blood lead screenings

Vaccines For Children (VFC) Program

The Vaccines For Children (VFC) program is a federally funded program administered by the State Bureau's Public Health Immunization Program, that helps provide immunizations to WV children younger than 19 years of age and is one of the following: Medicaid-eligible, Uninsured, Under-insured, American Indian, or Alaska Native. Vaccines available through the VFC program are those recommended by the Advisory Committee on Immunization Practices (ACIP) and approved by the Centers for Disease Control and Prevention (CDC).

For more information about the VFC program, visit:
https://www.cdc.gov/vaccines/programs/vfc/index.html

Surgical Sterilization Consent Forms

THP, in accordance with WV Medicaid / WVCHIP guidelines, will continue to require state surgical consent forms for:

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

The surgical sterilization consent forms for voluntary sterilizations must be completed and signed by the WV Medicaid / WV CHIP member 30 days prior to the surgery. The consent form is valid for 180 days. THP does not need the surgical consent form.

Surgical sterilization consent forms are available at https://healthplan.org/providers/resources.

Effective July 1, 2020, THP will reimburse for tubal ligation regardless of the number of days from the members consent and the tubal ligation.

Pregnancy Billing and Newborn Enrollment and Billing

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, THP adopted the state's pregnancy and newborn guidelines. THP requires all providers rendering antepartum care to submit the appropriate code for each encounter during the antepartum period; those antepartum services will be separately reimbursed. THP also requires separate billing for the delivery and postpartum services.

THP requires Prenatal Risk Screening Instrument (PRSI) to be completed upon the initial pregnancy encounter when the estimated confinement date (EDC) date is determined. Practitioners are asked to complete the PRSI and fax the completed form to THP at 740.695.5297.

The PRSI form is available on the Department of Human Services' (DoHS) Office of Maternal, Child and Family Health website: dhhr.wv.gov "Office of Maternal Child & Family Health" "WV Prenatal Risk Screening Instrument Form."

Based on this screening tool, THP contacts members to begin tracking their pregnancy. THP expects an initial prenatal care visit to be scheduled within fourteen (14) days of when a THP member 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, they are also referred to the tobacco cessation program. Outreach representatives monitor the low-risk pregnancies on a trimester basis. THP will encourage members to participate with the Women, Infant, and Children's (WIC) program.

When the THP MHT member gives birth, her newborn(s) is automatically covered from date of birth. THP's enrollment specialist calls new mothers in the hospital to enroll the newborn(s). The new mother is reminded to apply for a Social Security Number for the newborn and to select a PCP for the baby. THP will emphasize well-child visits and immunizations and will mail a newborn packet when mailing the newborn's member ID card.

THP's outreach representatives make postnatal contacts to mothers of newborns. This contact is done to remind the member to schedule a postpartum checkup within eight weeks of delivery and to review the Edinburgh Postnatal Depression Scale (EPDS) for postpartum depression. If the member has a high EPDS score, they are referred to THP's prenatal care coordinators who notify the member's OB provider.

Members 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, THP 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.

These services are in consultation with the attending practitioner and the member and approved as medically necessary and appropriate by THP.

THP 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

THP encourages members to participate in sponsored tobacco cessation classes which are free of charge. A THP staff member will provide the member with one-on-one personal support that can help the member with tobacco cessation. Members can qualify for THP's tobacco cessation incentive by completing the THP sponsored program. Providers can refer a member to this program and others on THP corporate website here.

Diabetes

THP covers Insulin pumps in specific medical cases. THP covers diet management and education. THP covers blood glucose monitors for diabetic members when a participating provider writes the order, and the monitor is obtained from a participating provider. For WV Medicaid, Continuous Glucose Monitors (CGMs) are covered under the fee-for-service pharmacy benefit. For WV CHIP, CGMs should be submitted as a medical claim to THP.

Diabetic members 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. THP sends diabetic members a yearly coupon as a reminder to have the dilated eye exam.

Medicaid Behavioral Health Services

THP provides behavioral health services as outlined in the Bureau for Medical Services (BMS) provider manual. BMS' provider manual may be accessed on the WV DoHS website.

The following BMS provider 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

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 prior-authorization list.

WVCHIP Behavioral Health Services

WVCHIP members do not need a referral for behavioral health services. THP's Member Services team can help families, primary care providers, or members locate behavioral health providers.

THP provides inpatient acute psychiatric care and outpatient behavioral health services to WV CHIP members. This benefit includes acute inpatient psychiatric care, outpatient mental health services, outpatient, and residential treatment for substance use (alcohol and drugs) services and Applied Behavior Analysis. All providers must be fully licensed and credentialed by THP before providing services.

Services may require prior authorization. Please visit THP's prior authorization requirement list **here**.

Behavioral Health Services Not Covered:

- Any services that are covered by fee-for-service
- School-based services
- Children's Residential Treatment

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 Billing Guidelines

THP requires credentialing of all licensed behavioral health practitioners operating within a practitioner'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 (OBMAT) program. For WV CHIP members, outpatient behavioral health services must be provided by a licensed medical or behavioral health practitioner who is credentialed by THP and listed as rendering provider on the claim. Please refer to **Chapter 11 - Credentialing** for credentialing information.

Unlicensed personnel may not bill for behavioral health services within a practitioner's practice except for 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 THP Medicaid members. A supervised psychologist must appear in the directory of the West Virginia Board of Examiners of Psychologists at psychbd.wv.gov/license-info/license-search.

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

This guideline does not apply to practitioner's offices within Licensed Behavioral Health Centers (LBHC). Although the billing procedures described below do not apply to FQHC/RHC, the requirement for credentialing does apply to these agencies.

THP, in conformity with Mental Health Parity rules, does not require prior-authorization for clinic-based behavioral health outpatient services. THP's prior- authorization list is available on the corporate website "For Providers" section.

Medicaid

Chapter 519.2 and Chapter 521 of the Bureau for Medical Services (BMS) provider manual describes the circumstances under which a licensed behavioral health practitioner may provide services under the auspices of a practitioner practice (these rules do not apply to practitioners employed by a licensed behavioral health center or an FQHC/RHC). The chapters are available on the WV DoHS' website.

OBMAT programs properly certified/registered with the Office of Health Facility Licensure and Certification Exception

This exception applies to members with WV Medicaid coverage/benefits.

Practitioners 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 practitioner.

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

- Licensed Psychologist
- Advanced Practice Registered Nurse (APRN)
- Certified Nurse Practitioner (CNP)
- Physician Assistant-Certified (PA-C)
- Supervised Psychologist officially approved by the West Virginia Board of Pharmacy (WVBOP)
- Licensed Independent Social Worker (LICSW)Licensed Certified Social Worker (LCSW)Licensed Graduate Social Worker (LGSW)Licensed Professional Counselor (LPC)

WV Medicaid requires all staff, except for LCSW and the LGSW, bill under their own rendering National Provider Identifier (NPI), using procedure codes without a modifier.

Staff other than LCSW and the LGSW must be credentialed with THP before they can bill for services. The LCSW and LGSW may bill under the practitioner's NPI with an AJ modifier on the CPT code and do not need to be credentialed by THP.

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 practitioner's NPI using the AJ modifier so long as the appropriate supervision requirements are met**:

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.

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

THP utilizes the following methodology for applications for credentialing all providers: WV Standardized Credentialing Application found on CAQH or WV Department of Insurance.

The rendering provider is required to have an individual National Provider Identification Number (NPI). A provider may obtain an NPI number on the NPPES website.

Commercial and self-insured policies may vary. Please call Behavioral Health customer services at 1.877.221.9295 with questions regarding these types of policy coverages.

THP 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 THP Special Investigations Unit (SIU) for fraud, waste, and abuse. New network providers may be requested to submit planned procedures for prepayment review. Out of network providers are required to submit prior authorization for all services.

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 THP's dental benefit administrator. Providers must contract with Skygen USA before providing services to THP members. To contact Skygen USA call 1.888.983.4690 or access their website and Provider Manual at skygenusa.com.

In addition to preventive and restorative dental care, THP members have access to emergent procedures to evaluate and treat fractures, reduce pain, or eliminate infection (without financial cap applied). Specifically, fractures of the mandible and maxilla, biopsy, removal of tumors, and emergency extractions.

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, then "Providers", then "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 require a prior authorization. Refer to the BMS website for covered oral health services for adults over the age of 21.

Medicaid Children's Dental

THP covers children's dental services (up to age 21). Skygen USA is THP's dental benefit administrator. Providers must contract with Skygen USA before providing services to THP members. To contact Skygen USA call 1.888.983.4690 or access their website and Provider Manual at skygenusa.com.

Children's (up to age 21) dental services rendered in hospital setting require the dental provider to obtain a prior authorization from Skygen USA. Skygen issues the prior authorization, the dental provider must contact THP at 1.888.613.8385 to obtain the prior authorization for the hospital services. THP prior authorization.

Oral Health Fluoride Varnish Program

Primary care providers may receive 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

The West Virginia statewide immunization information system (WVSIIS) for all children, adolescents, and adults is a confidential, computerized information system to maintain immunization records. Children often receive immunizations from several providers which fragments the immunization record , 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/wvsiis.

Appeals and Grievances

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 is 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 THP at 1.888.613.8385 (TTY:711)
- To file a complaint or grievance in writing, the member may fax it to THP 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.
- The doctor or authorized representative can also file a complaint or grievance for the member if written consent from the member was obtained prior to the doctor or authorized representative filing on their behalf.

THP will notify the member when a complaint or grievance is received. THP will conduct a full investigation and issue a decision between 30 calendar days and 90 calendar days; at times, THP may ask for extra time before making a decision.

THP will provide translation services, as needed, at no cost to the member who wants to file a complaint or grievance.

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 THP at 1.888.613.8385.
- To file an appeal in writing, the member can mail it to THP at 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, THP will acknowledge the appeal in a letter. A member must file an appeal within sixty (60) calendar days from the date on THP's notice of action.

THP will notify member their appeal was received. The member can obtain copies of documents, records, and information about the appeal without a charge. That information could include medical necessity criteria, and any processes, strategies, or evidence-based standards used in setting coverage limits. A THP Appeals Committee will review the member's appeal. THP's Appeal Committee includes does not include individuals involved in the initial decision to not authorize or pay for the services. If the appeal involves a medical issue, the THP Appeals Committee will speak with a health care professional with the appropriate training and experience necessary for making the decision. THP identifies the following titles and qualifications for the Appeals Committee members:

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

THP must process and respond to the appeal within thirty (30) calendar days.

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

THP will continue benefits during the time of an appeal process.

Fast (Expedited) Appeals

If an appeal is about our decision to not approve or to not 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 THP at 1.888.613.8385.

The member must request the fast appeal within (60) calendar days of the denial date.

If THP allows 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 THP determines that an appeal is not a fast appeal, THP 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 the information to:

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

If THP decides the appeal is not a fast appeal, then THP will handle as a normal appeal as described in the section above.

The member has the right to file a grievance if unhappy with the decision to deny the fast appeal.

THP will continue benefits during the time of an appeal process.

State Fair Hearing Process

If a member is not happy with THP'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, or provider on behalf of a member with written consent, 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 receive 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 THP's appeal decision. The member may also request a State Fair Hearing if THP does not meet the timeframe for deciding on the appeal.

Send requests for State Fair Hearing to:

Medicaid State Fair Hearing
Bureau for Medical Services Office of Medicaid Managed Care 350 Capitol Street, Room 251 Charleston, WV 25301-3708

The Bureau for Medical Services/WVCHIP' decision will be written to the member.

THP will continue benefits during the time of a 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. THP will pay for the services in question when the result of the appeal is to overturn the original decision. THP 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, THP may recoup reimbursement for those services while the appeal was in process, and the member will be responsible for paying for the services.

Grievances and Appeals Records

THP will maintain member grievance and appeals documents, records, and information for ten (10) years.

Mountain Health Trust Members' Rights

THP members have rights around their health care and to receive information according to contract standards. These rights and responsibilities are available at healthplan.org/legal/member- rights-and-responsibilities.

Annually on April 1, THP submits an annual report to the Bureau for Medical Services (BMS) and WVCHIP. This annual report includes a description of THP's services, personnel, and the financial standing. The annual report is available to members by request. To get a copy of the report, members can call Member Services at 1.888.613.8385. Members can also get a copy of the report from BMS/WVCHIP.

Members have the right to:

- Ask for and obtain all included information
- Be told about their rights and responsibilities
- Get information about THP's services, providers, and their rights
- Be treated with respect and dignity
- Not be discriminated against by THP
- Access all services that THP must provide
- Choose a provider in THP's network
- Take part in decisions about their health care
- Refuse treatment and choose a different provider
- Get information on available treatment options or alternative courses of care,
- Get information presented in a manner appropriate to the their condition and ability to understand, regardless of cost or benefit coverage
- Have their privacy respected
- Ask for and to get their medical records within 30 days of request
- Ask that their medical records be changed or corrected if needed within 60 days of request
- Be sure their medical records will be kept private
- Recommend changes in policies and procedures, including, but not limited to, member rights and responsibilities.
- 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 experiencing homelessness
- Refer themselves 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 their parent or a representative make treatment decisions when they 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 their member handbook annually after initial enrollment
- Disenroll from their health plan
- To exercise their rights. Exercising their rights does not adversely affect THP's treatment of the member
- Ask us about THP's quality improvement program and tell THP how they would like to see changes made
- Ask us about THP's utilization review process and tell us how you would like to see changes made
- Know the date they joined THP
- Know that THP only cover health care services that are part of their plan
- Know that THP can make changes to their health plan benefits after THP informs about those changes in writing
- Get news on how providers are paid
- Find out how THP decides if new technology or treatment should be part of a benefit
- Ask for oral interpreter and translation services at no cost
- Use interpreters who are not your family members or friends
- Know they will not be held liable if THP insolvent
- Know their provider can challenge the denial of service with your permission

MHT Member Responsibilities

- Read through and follow the instructions in THP's member handbook
- Work with their PCP to manage and improve your health
- Ask their PCP any questions
- Call their PCP at any time when you need health care
- Give information about your health to THP and your PCP
- Always remember to carry your member ID card
- Only use the emergency room for real emergencies
- Keep their appointments
- If they must cancel an appointment, call their PCP as soon as possible to let him or her know
- Follow their PCPs recommendations about appointments and medicine
- Go back to their PCP or ask for a second opinion if they do not get better
- Call Member Services at 1-888-613-8385 whenever anything is unclear
- Treat health care staff and others with respect
- Tell THP right away if they get a bill they should not have gotten or if they have a complaint
- Tell THP and their Department of Human Services (DoHS) caseworker right away if they had a transplant or if they are told they need a transplant
- Tell THP and DoHS when they change your address, family status or other health care coverage
- Know that THP does not take the place of workers' compensation insurance

Provider Reporting Requirements

Reporting of Required Reportable Diseases

State law requires health care providers are required to report certain diseases. 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 reportable diseases, as necessary to protect the public's health, or (2) screening, diagnosis and treatment of case contacts who are THP members. Detailed infectious disease reporting requirements can be obtained from the Bureau for Public Health within the Department of Human Services.

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

THP must comply with the following Federal reporting and compliance requirements for the services listed below and must submit applicable reports to BMS/WVCHIP. (See BMS 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 Fee Schedule Changes

In accordance with THP's contract with BMS, THP will update provider fee schedules as follows:

Federally Qualified Health Center / Rural Health Center (FQHC/RHC)

Upon BMS/WVCHIP notification to THP of any changes to the FQHC/RHC reimbursement rates, THP must update payment rates to FQHC/RHCs to the effective date in the notification by BMS/WVCHIP. THP 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, THP 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 Hospital (CAH)

Upon BMS/WVCHIP notification to THP of any changes to the CAH reimbursement rates, THP must update payment rates to CAH effective from the designated CMS effective date. 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 new payment rate must be loaded into THP's claims payment system within thirty (30) days of notification of the payment rate change.

Other Fee Schedules

THP is required to implement any rate changes adopted by BMS/WVCHIP within thirty (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. THP must reprocess any claims paid between the notification date and the system load date to the updated rate.

Provider Overpayments

In some situations, BMS/WVCHIP reserves the right to collect overpayments. If this were to occur, BMS/WVCHIP will directly notify the provider. 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). See **Chapter 3 – Claims** for additional provider overpayment information.

Alternative Payment Models (APMs)

THP collaborates with providers to develop APMs to best fit for the providers and members needs.

THP's APM include:

- Care coordination payments
- Pay for quality
- Pay for reporting
- Shared savings, upside only

THP will consider other APMs in the future, such as shared savings, upside and downside, or full risk, based on provider readiness.

Marketing Guidelines

THP may conduct general advertising that does not specifically solicit the MHT population. THP must submit marketing plans to BMS/WVCHIP for prior written approval.

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 approval;
2. Distributing Marketing materials written above the sixth (6th) grade reading level (Grade 6.9 or below), unless approved by BMS;
3. Making any assertion or statement (orally or in writing) that the MCO is endorsed by CMS, a federal or state government agency, or similar entity;
4. Making any written or oral statements containing material misrepresentations of fact or law relating to the MCO's plan or the Medicaid and WVCHIP program, services, or benefits;
5. Making false, misleading, or inaccurate statements relating to services or benefits of the MCO or Medicaid and WVCHIP program, or relating to the providers or potential providers contracting with the MCO;
6. Using the word, "Mountain," or phrase, "Mountain Health," except when referring to Mountain Health Trust or other State programs;
7. Marketing in or around public assistance offices, including eligibility offices;
8. Direct Mail Marketing to potential enrollees.
9. Directly or indirectly, engaging in door-to-door, email, text, telephone, and other Cold Call Marketing activities;
10. Using spam (an unwanted, disruptive commercial message posted on a computer network or sent by email);
11. Inducing or accepting an enrollee's MCO enrollment or MCO disenrollment;
12. Using terms that would influence, mislead, or cause potential enrollees to contact the MCO, rather than the Enrollment Broker, for enrollment;
13. Using absolute superlatives (e.g., "the best," "highest ranked," "rated number 1") unless they are substantiated with supporting data provided to BMS;
14. Portraying competitors in a negative manner;
15. Referencing the commercial component of the MCO in any Marketing materials;
16. Knowingly marketing to persons currently enrolled in another MCO directly by mail, phone, or electronic means of communication;
17. Influencing enrollment in conjunction with the sale or offering of any private insurance;

18. Tying enrollment in the Medicaid/WVCHIP MCO with purchasing (or the provision of) other types of private insurance;
19. Charging enrollees for goods or services distributed at MCO or Medicaid/WVCHIP events;
20. Charging enrollees a fee for accessing the MCO's website;
21. Using marketing agents who are paid solely by commission;
22. Purchasing or otherwise acquiring mailing lists from third party vendors, or for paying BMS' contractors or Subcontractors to send plan specific materials to potential enrollees;
23. Assisting with Medicaid/WVCHIP MCO enrollment form;
24. Conducting potential enrollee orientation in common areas of providers' offices;
25. Posting MCO-specific, non-health related materials or banners in provider offices;
26. Allowing providers to solicit enrollment or disenrollment in an MCO or distribute MCO-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 MCO materials.);
27. Providing gifts to providers for the purpose of distributing them directly to the MCO's potential or current enrollees;
28. Offering gifts valued over $15 or $75 annually to potential enrollees;
29. Making potential enrollee gifts conditional based on enrollment with the MCO;
30. Discriminating against an enrollee or potential enrollee 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 enrollees with certain diagnoses;
31. Failing to provide an opt-out option in SMS/text message materials.

Social Media Marketing Guidelines

THP must comply with the following social media marketing guidelines:

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

1. Upon BMS/WVCHIP approval, THP may engage in forms of social media advertising (i.e. Twitter, Facebook, Instagram)
2. Upon BMS/WVCHIP approval, THP may purchase advertisement banners on social media outlets. The content of such advertisements must be approved by BMS prior to distribution
3. THP 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. THP 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 social media sources must be processed and resolved through the general complaint intake system.

Social Media Prohibitions

The following prohibitions are applicable to THP , 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)
6. Tagging individuals on social media

Reporting and Investigating MCO Marketing Violations

THP's process to ensure fair and consistent investigation of alleged violations of BMS/WVCHIP marketing policies is:

Upon written receipt of any alleged violation(s) from BMS/WVCHIP, THP 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

THP 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 THP's members may not be held liable for THP's debts in the event of THP'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 THP not specifically exempt.

C. Other Obligations of Practitioner

- Practitioner may not refuse to furnish covered services to the eligible member on account of a third party's potential liability for the service(s).
- Practitioner agrees to comply with THP'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. THP is not required to contract with a provider enrolled with the West Virginia Bureau for Medical Services/CHIP that does not meet THP's credentialing or other requirements.
- Practitioner 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 THP immediately at the time it receives notice that any action is being taken against a practitioner 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 Providers must comply with timeliness of access standards as defined by BMS/WVCHIP.

D. THP's Reimbursement Responsibilities

- THP 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.
- THP 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.
- Members may not be held liable for covered services, for which 1) the State or THP does not pay the individual or health care provider that furnished the services under a contractual, referral, or other arrangement; or 2) payments for covered services furnished under a contract, referral, or other arrangement to the extent those payments are in excess of the amount that the enrollee would owe if THP covered the services directly.

E. Reporting Actions against Providers, Owners, or Others

- Provider must notify THP 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 THP 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 THP 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, THP 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 THP, 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 THP 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;
- 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 THP 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 THP'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 THP; 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 THP 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 THP. 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 THP and the State

- Provider shall take no actions that interfere with or place any liens upon the State's right or THP'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 THP, 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 THP 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 THP to provider
  - The payment occurred outside the grace period, as defined by BMS/WVCHIP
  - THP 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 THP.
- 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

THP's policies regarding drug testing are guided by the American Society for Addiction Medicine. Please consult the ASAM White Paper on drug screening on the THP website at www.healthplan.org for further clinical guidelines on use of definitive/definitive drug testing.

- WV Medicaid coverage will be based on WV Bureau of Medical Services (BMS) Policy and Medical Review Criteria. https://dhhr.wv.gov/bms/Pages/Chapter-529-Laboratory-Services.aspx
- WV BMS has established specific limitations on number of services that may be covered for specific timeframes of treatment without further authorization. For additional information go to: https://dhhr.wv.gov/bms/Pages/Chapter-529-Laboratory-Services.aspx
- THP's prior authorization form must be completed to assist in reviewing the indication and medical necessity of the testing requested.

- Limitations in number of services during management of both addiction treatment and pain management will be based on the guidelines as cited above. Additionally, to assure medically appropriate services are provided, prior authorization will be required as follows:
- Presumptive tests - more than 24 in a contract year require prior authorization. Please note the minimum eight required panels delineated in Chapter 503 of the BMS manual;
- Definitive tests, –are limited to twelve (12) per calendar year without authorization.
- Effective January 1, 2023, HCPCS codes G0481, G0482, G0483 and G0659 definitive tests will require prior authorization and medical necessity review from the initial service.

All drug testing as part of pain management and/or substance use treatment/recovery is a clinical determination and should influence the treatment plan, be based on the stage of treatment and patient presentation, and the medical necessity should be supported in the clinical record.

Medical Necessity Documentation Guidelines

All Drug screenings must be ordered by the treating practitioner operating within his/her scope of practice.

Presumptive testing (CPT codes 80305-80307) is a routine part of initial and ongoing patient assessment.

- Phase of treatment
    - beginning or induction phase - usually less than 30 days of abstinence
    - middle or stabilization phase – usually 31 – 90 days of abstinence
    - maintenance phase - > 90 consecutive days of abstinence
- Baseline screening before initiating treatment or at the time treatment is initiated (i.e., induction phase), once per program entry when the following are met:
    - A clinical assessment of member history and risk of substance abuse is performed;
    - The clinician has a working knowledge of basic test interpretation and
    - There is a plan in place regarding how to use test findings clinically.
- Additional presumptive testing throughout the Stabilization phase and Maintenance phase may be appropriate to monitor adherence and progression.
- Documentation must support how results will have an impact upon treatment.

Definitive testing techniques (HCPCS codes G0480-G0483, G0659) are intended to be used when a provider wants to detect specific substances not identified by presumptive methods and quantify levels of the substance present.

Definitive testing techniques may be indicated in the following clinical situations:

- When the results inform clinical decisions with major clinical or non-clinical implications for the patient (e.g., treatment transition, changes in medication therapies, changes in legal status).

- If a patient disputes the findings of a presumptive test
- When ordering a definitive test, providers should advise the testing laboratory if the presence of any particular substance or group of substances is suspected or expected. Not all laboratories automatically perform a definitive test of positive presumptive results (the common term for this is "reflex" testing); providers should be aware that laboratories may require a specific order for definitive testing.
- Definitive testing should not be performed to confirm substances that are expected to be present on a presumptive test that would provide limited clinical value (e.g., testing for THC levels after a member admits to regular cannabis use.)

Documentation of medical necessity for definitive drug testing should be individualized. Medical necessity of definitive drug testing used in treatment of substance use disorder is based on the following information that should be clearly evident in the medical record.

Stage of treatment

- beginning or induction phase - usually less than 30 days of abstinence
- middle or stabilization phase – usually 31 – 90 days of abstinence
- maintenance phase - > 90 consecutive days of abstinence

Unusual circumstance such as initial treatment or relapse;

Exam findings, including the following:

- Documented recent substance use

- Patient disclosed use
- Identification of whether the testing was random or scheduled
  - Presumptive test findings
  - If the presumptive test is negative, what signs and symptoms are present during the visit that raise suspicions to justify definitive testing
  - List of the medications and herbal products the patient is taking that may lead to "false positives" on the presumptive tests.

  A description of how the results will modify the treatment plan as follows, including:

  - Impact on level of care
  - Continuation / discontinuation from treatment program
    - Of note, if the definitive test results will not impact the treatment plan, the ordering of the expanded testing is questionable.

  Number of drug classes being assessed should correlate with regional exposure and known history of drugs of abuse

Limitations and Exclusions:

Limitations and exclusions in coverage are based on CMS and/or West Virginia BMS established guidelines.

Standardized statements of need for definitive testing in the file/electronic health record are not acceptably individualized clinical justification for the tests.

THP does not reimburse testing ordered for the purpose of employment screening or satisfaction of a court order.

Participation in an OBMAT or other substance use treatment program is not in and of itself justification for ordering definitive tests.

"History of SUD/OUD" is not in and of itself justification for ordering definitive tests (exception being the initial testing done when the member enters the program).

Pregnancy Testing

Participation in an office-based Medication Assisted Treatment (OBMAT) program is not in and of itself sufficient justification for frequent pregnancy screening. THP defines frequent pregnancy screening as more than once per month.

Medical necessity criteria for pregnancy testing in an OBMAT program for substance use disorder (SUD) includes:

- The patient is female, not postmenopausal nor has a confirmed pregnancy
- The visit is an initial screen for entry into the practice; and/or
- The patient has a history of engaging in high-risk heterosexual behavior (claim billed with ICD-10 diagnosis code Z72.51 and the provider has documented high-risk behavior in the medical record); and/or
- The patient is complaining of symptoms possibly suggestive of pregnancy; and/or
- The patient has reason to express concerns that she may be pregnant; and/or
- The patient requires medical clearance for some type of procedure or medication which may be potentially harmful to the fetus; and/or
- The patient requests pregnancy testing

Providers should judge for themselves their degree of comfort with treatment agents containing both Naloxone and Buprenorphine and order testing, accordingly, documenting the need for such testing in the clinical record.

Breathalyzer

THP will deny all breath alcohol testing (82075) performed in conjunction with any urine drug screen other than dipstick point of care testing (POCT) (80305). Providers using more complex urine drug testing such as 80307 or a definitive screen are encouraged to include alcohol as a screened substance. Breathalyzer testing should be performed only if the member:

- Has a history of alcohol use that is not currently controlled; or
- The member appears intoxicated or smells of alcohol and denies alcohol use.

Automatic use of breathalyzer testing without justification may be reviewed and denied if not deemed medically necessary.

Oral Fluid Testing

According to Medicare guidance on drug screening, "Urine or oral fluid is the preferred biologic specimen for testing because of the ease of collection, storage, and cost-effectiveness."

Oral fluid methods of point of care testing have proven to be 97 to 99% effective in detection of most drugs utilized within 5 to 48 hours of the test. Oral fluid testing has, in some research, proven to produce fewer false positive results than similar urine point of care testing. The methodology is painless and non-invasive, respecting the member's right to privacy while honoring the provider's need for accurate, observed samples. Oral fluids have reliably proven to be harder to tamper with than similar urine point of care testing. Positive results will appear immediately after use whereas urine tests require that the body metabolize the substance prior to becoming evident in urine POC sampling.

Providers electing to utilize the oral fluid method of drug screening must comply with the following:

- Members must be continuously observed for 10 minutes prior to the sample collection.
- The member may not consume any fluid or food during that time, nor may the member chew gum, smoke, rub tobacco, or introduce any foreign material into their mouth during the 10-minute observation.
- The provider must document the methodology utilized for the screen (oral vs urine).
- Only FDA approved equipment/tests may be utilized.
- Breathalyzer (82075) may not be billed at the same date of service as the oral fluid panel.
- Billing code 80305 (Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; capable of being read by direct optical observation only (e.g., utilizing immunoassay [eg, dipsticks, cups, cards, or cartridges), includes sample validation when performed, per date of service) is to be used for this point of care screening.

Transplant Services

Members receiving transplant services, with the exception of retinal transplants, are exempt from managed care.

Inpatient Claims

THP processes 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

THP will not 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 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 (https://dhhr.wv.gov/bms/BMS%20Pharmacy/Documents/FAQsNDC_HCPCS_012712_v.%208.pdf).

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 Teams 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. 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. THP 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

Bureau for Medical Services (BMS) requires board certification for all new and existing Peer Recovery Support Services personnel (PRSS) through the West Virginia Certification Board for Addiction and Prevention Professionals (WVCBAPP). WVCBAPP certification requirements, applications and manuals may be accessed online at https://www.wvcbapp.org/applications

THP will not reimburse services provided by a non-WVCBAPP certified PRSS or PRSS personnel not employed by the LBHC.

PRSS personnel must include the rendering NPI on claims.

Medicaid Emergency Room (ER) All-Inclusive Reimbursement Rate

THP follows BMS' reimbursement policy for ER all-inclusive reimbursement rates.

The ER all-inclusive reimbursement rate includes
- 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 O_2 saturation monitoring

Diagnostic procedures including lab and radiology performed during an ER visit 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 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 one (1) unit and $0.01 charges.

Indian Health Care Providers 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 provide.

Member Incentives (Value Added Services)

Members may qualify for incentives by completing health activities. By helping members complete these activities, providers can help THP reward patients who receive needed services.

THP's 2023 member incentives include:

Value-Added Services

- **Annual well visits:** Ages 3-21 - Receive a $25 gift card.
- **Maternity:** $100 gift card for six prenatal visits and $50 for post-partum visit between 7-84 days of delivery.
- **Diabetes:** $25 gift card for completion of an HbA1c blood test and $25 gift card for a diabetic eye exam for ages 18-75.
- **Dental:** $25 gift card for dental exams for children up to age 21.
- **Mammogram:** $50 gift card for completion of a mammogram, ages 40+.
- **Pap Smear:** $25 gift card for completion of a Pap smear.
- **Colorectal Screening:** $25 gift card for men and women aged 45-64 for completing an exam.
- **Free Cell Phone:** Free cell phone with free minutes for text and voice, unlimited calls to Member Services and free wellness and appointment reminder texts. (Medicaid-only)
- **Boy and Girl Scouts** annual membership fee for ages 5-18.
- **Participation in Member Advisory Committee:** Assist THP with better understanding how to meet your needs
- **Jobs and Hope West Virginia Assistance:** Assist members in referral program.
- **Teladoc**: 24/7/365 access to providers for non-emergent treatment.
- **Meals for Moms**: New moms may receive a week's worth of meals following discharge from hospital after newborn delivery.
- **COVID Vaccine**: $25 gift card for completing COVID vaccine (limited to 1 gift card)
- **Life Coach:** Available to assist with resume development, interview skills and job searches.
- **Smoking Cessation:** $25 gift card for completing THP smoking cessation course (effective 1/1/2022)
- **Health Risk Assessment:** $25 gift card for members up to age 21 for completing a Health Risk Assessment (effective 1/1/2022)

These incentives are subject to change January 1 and July 1 each year. Please contact Member Services to verify most current value adds. Please allow up to six (6) months to receive gift card funds.

TheHealthPlan

Chapter 6

Medicare Advantage (MA)

Provider Manual

SecureCare HMO Medicare Advantage Plan

THP 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 THP for each Medicare beneficiary who enrolls in our plan. This contract requires THP to provide comprehensive health services to persons who are entitled to Medicare benefits and who choose to enroll in THP. THP 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

The benefits for SecureCare Health Maintenance Organization (HMO) members are identical to traditional Medicare benefits along with additional enhanced benefits . rights and responsibilities as a participating provider with THP. 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 Customer Service Department is available to assist with any member issues that may arise at 1.877.847.7907.

Medicare Advantage Member ID Cards

The THP Medicare Advantage member ID cards are color-coded orange to more easily identify THP's Medicare Advantage population.

FRONT

BACK

SecureChoice PPO Medicare Advantage Plan

SecureChoice Preferred Provider Organization (PPO) is THP'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. THP prior authorization requirements do apply.

The SecureChoice PPO plan provides benefits at an "in-network" level from THP'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.

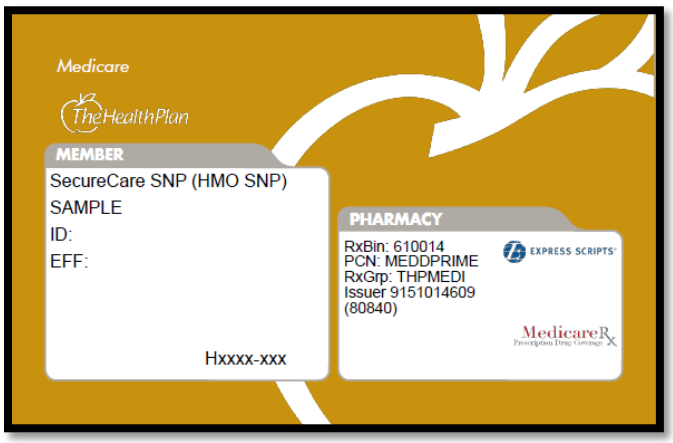
The benefits for SecureChoice PPO members are identical to traditional Medicare benefits. THP also offers enhanced benefits for SecureChoice members. As with the SecureCare HMO plan, it is imperative that you are aware of these rights and responsibilities as a participating provider so that you may assist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

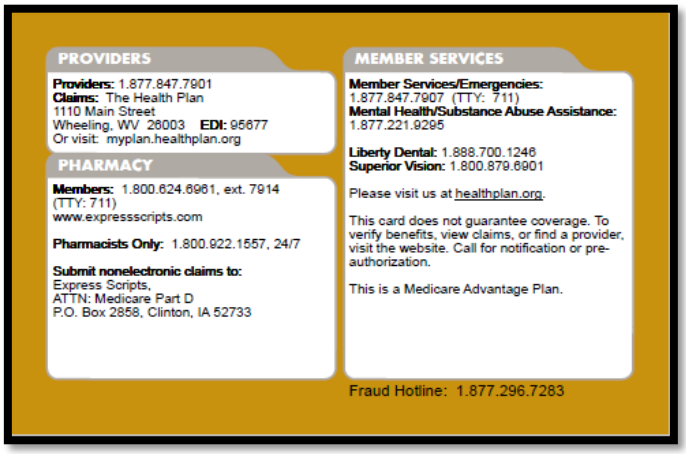
D-SNP Medicare Advantage Special Needs Plan

Effective January 1, 2014, THP began a Medicare Special Needs Plan (SNP) for populations that are dually eligible for both Medicare and Medicaid coverage. These Dual Eligible Special Needs Plan (D-SNP) members are individuals with both Medicare Part A and Part B coverage who also meet the Medicaid eligibility requirements of their state of residence.

Every SNP is required to have a Model of Care (MOC) approved by the National Committee for Quality Assurance (NCQA). The NCAQ MOC approval process follows standards and scoring guidelines established by Centers for Medicare and Medicaid Services (CMS). THP received approval as a contracted MA-PD (Medicare Advantage Prescription Drug) plan, which also applies to THP's D-SNP program.

THP's developed MOC is a written document describing the fundamental framework and measurable goals of the program. THP's MOC implements a comprehensive approach to managing and coordinating care to enhance access to medically necessary care, improve quality of care and ensure continuity of needed services. The care management team uses a Health Risk Assessment Tool (HRAT) designed to assess information collected from the enrollee about their self-perceived health status and develop an individualized plan of care. As mandated by Medicare, THP provides initial and annual MOC training to personnel and providers (network and out-of-network) about the program to ensure integrated coordination of care for the D-SNP population.





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 provider (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 THP for medically appropriate covered services provided to the D-SNP member. THP 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. THP accepts full and partial D-SNP members. Members who have partial status may have limited coverage from their state plan.

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

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 pay 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 on the Social Security Administration's website: ssa.gov "Compilation of the Social Security Laws."

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

Provider education

In each calendar year, all Medicare Advantage participating practitioners must complete D-SNP MOC training. THP conducts provider education through several approaches including face-to-face or web-based training, seminars, and ProviderFocus newsletter articles.

THP's D-SNP MOC Annual Training and attestation are on the secure provider portal.

If training is not complete and attested to, THP will issue the provider a documented corrective action plan (CAP).

Each CAP will include a sixty (60) day cure period. During the sixty (60) day cure period, THP will:

1. Stop D-SNP member auto-assignment to network providers with incomplete D-SNP MOC training.

2. Suspend Alternative Payment Model Category 2 care coordination fees for assigned members, as applicable.

If the CAP is cured, THP will re-start member auto-assignment and re-institute care coordination fees, as applicable. If the CAP is not cured, THP will evaluate network providers for removal from the network.

Vision Service Benefit

Members enrolled through THP Medicare Advantage program also have vision benefits. Superior Vision administers routine vision benefits for Medicare Advantage members. Please refer to resources available through Superior Vision for information on benefits and coverage under these vision plans.

Providers must participate with Superior Vision before offering covered vision services to THP members.

Supervisor Vision is available at: superiorvision.com and 877.235.5317 Monday – Friday 8 a.m. to 9 p.m. EST and Saturday 11 a.m. to 4:30 p.m. EST

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 THP. A referral from the primary care provider (PCP) may be required for the member to obtain medical services from an ophthalmologist or optometrist.

Billing Medical Eye Exams with a Vision Screening

In most situations, a vision screening (CPT 92015 Determination of Refractive State) is considered non-covered and not separately reimbursed as it is a component part of an eye exam.

Billing Procedures

The visit is billed to THP with the following codes:

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

Coordination of Benefits Medicare Advantage Secondary Payer

Medicare Advantage is not always the primary payer for health insurance claims. THP 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

Original Medicare beneficiaries who have Original Medicare as their primary insurance can select a THP Medicare Supplement Plan and pay a monthly premium to THP to cover their Medicare deductibles and coinsurance. These plans do not require a member to choose a primary care provider (PCP) or obtain a referral for specialty physician services.

Medicare Non-Covered Service Guidelines

THP Medicare Advantage plans, SecureCare (HMO), SecureChoice (PPO), or SecureCare SNP (HMO SNP), fall under Medicare Advantage (Part C) rules. These rules require THP 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 THP 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 prior authorization, coverage determination, or organization determination) process.

For every service billed to THP, 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 (i.e., 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

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, THP 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 THP 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 THP, you must always submit a claim for payment of services to THP 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 on the claim*

- 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, THP will deny your claim as

provider responsibility. If you bill us for covered services with the GY or GA modifier, THP 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 THP. For THP 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 THP.

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 available on CMS' website cms.gov:

Medicare Advance Written Notices of Noncoverage ICN 006266

CMS Quality Measures/Standards

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. Please review the information found under **Chapter 10 - Quality** for additional information.

Quality measures are tools that help 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.

Medicare Wellness Visits

Medicare has distinct opportunities for practitioners to evaluate and treat beneficiaries, each of which has very specific purposes and claim submission requirements. THP encourages practitioners to complete the visits according to Medicare requirements to develop a personalized prevention plan, competed health risk assessments and fully assess social determinants of health and report this information via claims data.

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 if 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 in English, Spanish & Large Print. Visit https://www.cms.gov/medicare/cms-forms/cms-forms/cms-forms-items/cms012207 to access the form in these versions.

Notice of Medicare Non-Coverage (NOMNC)

When to Deliver the NOMNC

A Medicare provider, or THP, must deliver a completed copy of the Notice of Medicare Non-Coverage (NOMNC) to beneficiaries (or the beneficiary's appointed or authorized representative) for 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 (https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c30.pdf) or Section 100.2 in the Part C & D Enrollee Grievances, Organization/Coverage Determination, and Appeals Guidance Section of the Medicare Managed Care Manual (https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Parts-C-and-D-Enrollee-Grievances-Organization-Coverage-Determinations-and-Appeals-Guidance.pdf.)

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 Forms are available on the CMS website CMS.gov https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Notices-and-Forms

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 CMS.gov https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Notices-and-Forms

THP 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 (Parts C&D Enrollee Grievances, Organization/Coverage Determination, and Appeals Guidance – 50.1) An enrollee, an enrollee's representative or a non-contract practitioner 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 practitioner 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 practitioner 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 provider in THP'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 practitioner requesting the reconsideration and the enrollee, a Medicare health plan is to undertake reasonable efforts to confirm the practitioner has given the enrollee appropriate notice. For example:

- If the practitioner makes the request by phone, during the call a health plan may confirm the practitioner 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

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 CMS.gov.

Detailed Notice of Discharge (Form CMS 10066)

A member who wishes to appeal the determination made by the facility or THP 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 THP or the admission did not constitute emergency or urgently needed care and the PRO upholds THP'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 THP through the appeal process.

Forms and instructions can be found on the CMS website CMS.gov.

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.

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.

Medicare Provider Rights and Responsibilities

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 Physicians and Practitioners Must

- Arrange for the provision of medical services to THP'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 THP.
- 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 THP, 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 THP medical records policy, quality assurance programs, medical management programs, and HEDIS® data collection.

CMS Marketing Guidelines:

- Comply with CMS Marketing Guidelines (available online at https://www.cms.gov/Medicare/HealthPlans/ManagedCareMarketing/FinalPartCMarketingGuideli nes) for provider-based activities. The guidelines govern how providers can and cannot inform or educate patients about enrollment and plan information.

SecureCare/SecureChoice Member 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 Customer 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 THP 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. 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 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. THP 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 THP 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
    - THP tries to keep pace with change and ensure members have access to safe and effective care. THP 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. THP 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, medicare.gov, 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.

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 Customer 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 Customer Services for help if you have questions or concerns. We also welcome any suggestions you may have for improving our plan.
  - Call Customer Services at 1.877.847.7907.
- 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.

TheHealthPlan

Chapter 7

Behavioral Health

Provider Manual

Introduction

THP's nurse navigators (case managers) blend behavioral components such as motivational interviewing with disease management and other aspects of medical and behavioral health case management to address THP member needs. The care manager may link the member to primary care, specialty care, and behavioral health practitioners and address social determinants of health.

Refer to **Chapter 8 - Clinical** for information about integrated care for or THP members.
THP's 24-hour phone number is 1.866.NURSEHP (1.866.687.7347) for any THP member needs. This number is answered by nurse navigators who can assist providers and members.

Behavioral health admissions may be reported by phone to 877-794-7152- (reverts to voicemail after regular business hours), or through THP's secure provider portal at myplan.healthplan.org.

Review Criteria

Nationally recognized clinical criteria are utilized to perform reviews for medical appropriateness, allowing for consideration of the needs of the individual member's circumstances, medical history, and availability of care and services within THP 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 (PAC). When 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® Criteria

THP utilizes Change Healthcare InterQual® criteria as a screening guideline to assist reviewers in determining the medical appropriateness of health care services. Any participating practitioner, upon request, may review the specific criteria used in an active clinical review process of a procedure requiring the use of InterQual®.

THP uses InterQual® guidelines for most procedures and services other than for Mountain Health Trust (MHT) groups for whom West Virginia's Bureau of Medical Services has mandated use of other criteria for specific services (see BMS provider manuals at dhhr.wv.gov/bms).

ASAM Criteria

THP utilizes nationally recognized criteria known as ASAM (American Society of Addiction Medicine) for a comprehensive set of guidelines, continued stay and transfer/discharge of patient with addiction and co-occurring conditions.

Please indicate if your request is emergent so that we may expedite the review. Scheduling the testing/procedure does not warrant an expedited review. Unless an emergency, scheduling should be done after being approved by THP.

Behavioral Health 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.

The Behavioral Health Prior Authorization Requirements are available on THP's corporate website.

THP 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 other services for employer-funded groups based on individual plan documents.

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

All inpatient services require admission, concurrent, and discharge review by THP. Only elective admissions require a prior authorization. Admissions to residential facilities for substance use disorders (SUD) 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. Intensive Outpatient Programs and Partial Hospitalization Programs are outpatient services that provide a less intensive level of care, and THP will not require authorization for the first thirty (30) sessions for participating practitioners.

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

If the information submitted does not meet review criteria for admission and/or continued stay, THP nurse navigator will forward the clinical information for review to a practitioner for evaluation. The practitioner 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 practitioner will be notified when a determination is made. If there is an adverse decision, the practitioner can request reconsideration and further review. THP member or their designated representative may appeal as per policy for the line of business. A practitioner may request a peer-to-peer consultation with a THP practitioner 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 at least three (3) times per week, three (3) hours per day, depending on the program's structure THP will not require authorization for the first thirty (30) sessions for participating practitioners. Facilities should be aware of the following :

- Additional IOP services beyond the thirty (30) sessions can be requested. . If the sessions meet criteria for continued programming, the nurse navigator or the referral coordinator will continue to allow the course of treatment and inform the facility of the number of additional sessions approved. This will continue until discharge.
- Discharge clinical - summaries should be submitted for continuity of care.
- If the reviews do not meet criteria, the information submitted by the facility will be sent for practitioner review prior to denial of services.
- IOP services for practitioners not in network-, will be reviewed for medical necessity upon admission. Medical necessity will continue to be reviewed through discharge.
- Facilities providing IOP to MHT 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 from, traditional inpatient care for members with moderate to severe symptoms. Treatment is an individualized, coordinated, comprehensive, multidisciplinary program. THP members participate in this structured program up to five (5) days per week, four (4) to five (5) hours per day. Medication management is an integral aspect of partial hospitalization services. THP will not require authorization for the first thirty (30) sessions for participating practitioners.

Facilities should be aware that:

- Additional Partial Hospitalization services beyond the initial 30 sessions can be requested by submitting a request by fax, phone, or electronic transmission as noted above. If the sessions meet criteria for continued programming, the nurse navigator or the referral coordinator 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 summaries should be submitted for continuity of care.
- 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 Mountain Health Trust members must be certified by the WV Bureau for Medical Services.

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 practitioner. 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 PCP), referring participating specialist or admitting 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 required within 48 hours of admission. This process is in place to generate early discussion of the member's needs as related to the admission, identify alternative health care services, and initiate discharge planning. THP 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. THP will assist with members needing care by out of network practitioners when participating providers are temporarily not available or accessible.

All inpatient acute psychiatric and detox services require prior authorization**.** Clinical information is reviewed for availability of service in- network, urgent/emergent situations, or other extenuating circumstances. The information should be supplied by the relevant behavioral health practitioner.

Concurrent review processes are designed to provide oversight of member progress, ensure delivery of quality care, and promote effective discharge planning. At admission, members are referred by the behavioral health inpatient nurse navigator or behavioral health member advocate to the behavioral health transition of care manager (BH TOCM) assigned to that facility. The BH TOCM's primary goal is to facilitate communication, either face-to face or telephonically, and work collaboratively with members, facilities, and community-based providers to assure successful delivery of behavioral health transition of care services and promote continuity of care and discharge planning.

Inpatient Rehabilitation Facilities

THP will reimburse for treatment in inpatient rehabilitation facilities such as substance use disorder (SUD) treatment programs, Psychiatric Rehabilitation Treatment Facilities (PTRF)for individuals under age 21 , adult psychiatric rehabilitation facilities . and short-term residential eating disorder programs, depending on the terms of a specific benefit plan. Treatment must meet medical necessity criteria and must be authorized. The program must be approved by the Bureau for Medical Services for MHT 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 outpatient behavioral health practitioners. Prior authorization is not required for crisis visits or urgent or emergent services. Prior authorization is no longer required for psychotherapy visits or psychological testing depending on the specific benefit plan Contact THP if you have questions regarding a particular procedure or test.

All out-of-network and tertiary requests require prior authorization. Clinical information is reviewed for availability of service in network, urgency/emergency of the situation, or other extenuating circumstances. This information should be supplied by the behavioral health practitioner, PCP, or appropriate participating specialist.

Additional services that require prior authorization include procedure(s) that may have limited coverage under the benefit plan., Experimental and Investigational procedures that have specific coverage guidelines should be prior authorized to assure medical appropriateness and compliance with established standard of care guidelines.

Any prior authorization that does not meet medical appropriateness review by the nurse navigator or referral coordinator is referred to a medical director for review determination. The medical director may contact the behavioral health practitioner 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.

Please indicate if your request is urgent so that we may expedite the review. Scheduling the test/procedure does not warrant an expedited review. Unless an emergency, scheduling should be done after the service is approved by THP.

THP reserves the right to conduct clinical and utilization management reviews retroactively on a random or targeted basis to ensure medical necessity and the quality and appropriateness of the service provided.

Drug Screening and Testing

Urine drug testing is most effective when individualized, randomized, and conducted in conformance with principles of assessment recommended by the American Society for Addiction Medicine located on the ASAM website.

ASAM recommends against routine use of definitive testing. Please review the consensus paper available at the link above. Clinical procedures may 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.

Billing

THP requires credentialing of all independently licensed behavioral health practitioners within a practitioner practice.
Unlicensed personnel may not bill for behavioral health services within a practitioner's practice except for 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 in the directory of the West Virginia Board of Examiners of Psychologists at https://psychbd.wv.gov/license-info/license-search/Pages/default.aspx.
THP, in compliance with mental health parity rules, does not require prior authorization for clinic-based behavioral health outpatient services. THP's authorization list is available on the corporate website healthplan.org under the "For Providers," "Prior Authorizations."
THP defaults to CMS policy as interpreted for Medicare for our Commercial plans unless the plan description specifies otherwise.

Medicare Advantage and Commercial Fully Insured Plans

THP follows Medicare billing requirements for behavioral health "incident to" services provided by a practitioner. A summary of these requirements was developed by the National Council for Behavioral Health.
If a licensed behavioral health practitioner is employed or contracted by a practitioner whose scope of practice includes behavioral health, the licensed behavioral health practitioner may bill using the practitioner'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 practitioner's NPI if the scope of the service provided is consistent with the counselor's certification.
If a practitioner is federally certified as a Medication Assisted Treatment practitioner, regardless of the practitioner's specialty, the practitioner may have behavioral health practitioners employed or contracted in his office billing incident to the practitioner's services only so long as the service being provided relates to the practitioner's practice as a MAT practitioner if the practitioner's specialization is not traditionally behavioral health i.e., 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 practitioner 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 practitioner must provide regular reviews of the patient's status which must be documented in the medical record.
Medicare will reimburse "incident to" claims at 100% of the established Medicare rate for the service.
If the licensed behavioral health practitioner is listed on the claim as the rendering practitioner, the claim will reimburse at 85% of the established Medicare rate. All services must be provided at place of service 11, office.

Access to Care

To comply with NCQA standards, THP holds to the following standards for access to care for behavioral health cases:

- Practitioners should provide care within six (6) hours in an emergent, non-life-threatening case.
- Practitioners should provide care within 48 hours of a request for service when the case is urgent.
- Practitioners should provide a follow-up appointment within seven (7) days of discharge from an inpatient facility
- Practitioners should provide a new routine office visit within ten (10) business days
- Prescribing practitioners should provide a follow-up visit within thirty (30) business days
- Non-prescribing practitioners should provide a follow-up visit within twenty (20) working days of the initial visit.

If the provider is not available, the member must be informed how to access care after-hours, holidays, and weekends.

Continuity and Coordination of Care

THP Clinical Services Department advocates continuity and collaboration of care between behavioral health and physical health practitioners. Continuity and coordination are 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 practitioners whenever clinically appropriate.

It is the responsibility of the behavioral health practitioner to communicate with the PCP and the PCP to communicate with the behavioral health practitioner. Information that is shared between practitioners 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.

All federal and state confidentiality laws should be followed. THP expects that information be shared accordingly and recognizes the right to keep progress notes private. THP also understands that there are special situations where information cannot be shared.

Behavioral Health Services Forms

The following forms are provided to assist practitioners in requesting services for members and providing information necessary for continuity and coordination of care The forms listed below are available online at myplan.healthplan.org .

Admission, concurrent, and discharge reviews may be called to the nurse inpatient navigator.

- 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 MHT Member Services
- Prior authorization of Drug Screening (labs)
- Request for ACT Programming – MHT Line of Business only
- Peer Recovery Support Services authorization request (MHT Line of Business only)
- Request for ECT
- IOP/PHP Request for Authorization

Please call customer service at 1.800.624.6961 if you have a question about a particular benefit.

Telehealth Services

Telehealth services must be conducted using an interactive audio and video telecommunications system that permits real-time communications between the practitioner 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 CMS and BMS standards.

Telehealth services will be paid to behavioral health practitioners 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 eligible to provide telehealth include, but are not limited to the following: licensed psychiatrists, psychiatric nurse practitioners, clinical nurse specialists, physician assistants, licensed clinical psychologists, licensed professional counselors and therapists, and clinical social workers.

THP follows CMS criteria for telehealth services for all lines of business, except for Mountain Health Trust that follows WV BMS policies.

CMS telehealth guidelines are described here: **https://www.cms.gov/files/document/mln901705-telehealth-services.pdf**

In general, behavioral health service rules regarding telehealth are more flexible than for some other services, however in no circumstance does texting, instant messaging, or email qualify as a telehealth service. Documentation must include the location of the practitioner and the member, an identification of the service as telehealth in nature, and a description of the methodology (audio/visual, audio only, etc.)

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 practitioner within seven (7) days of discharge.

Practitioners should:

- Communicate to the hospital discharge planners that follow-up appointments should be scheduled within seven (7) days of discharge.
- Uploading discharge documentation on the secure provider portal if you are a facility provider so that we may help to reinforce your discharge plan.
- Schedule appointments for discharging patients within seven (7) days of discharge. If you require assistance in this process, please contact Clinical Services at [1.877.221.9295] for a nurse navigator.

TheHealthPlan

Chapter 8

Clinical

Provider Manual

Introduction

The Health Plan's (THP)'s clinical services program ensures the provision of appropriate health care 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 clinical services 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 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 and engage members appropriate for health and wellness/preventive care and clinical programs.
- Assess clinical services 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 clinical services programs and Clinical Services Division.

Prior Authorization Criteria

Nationally recognized clinical criteria are utilized to perform reviews for medical appropriateness allowing for consideration of the needs of the individual member, their circumstances, medical history, and availability of care and services within THP network. Input is sought annually, or as needed, in the review of criteria from practitioners in the community and those who serve as members of the Physician Advisory Committee (PAC). 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.

Medical Prior Authorization & Notification Requirements

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.

To comply with West Virginia prior authorization regulations (Senate Bill 267) providers requesting prior authorizations for MHT, WV Commercial, and WV PEIA members are required to submit prior authorizations through THP's secure provider portal.

Effective July 1, 2024, fax and phone prior authorization requests will not be accepted from providers.

To register for THP's provider portal, please visit **myplan.healthplan.org** to begin.

Effective January 1, 2024, THP will follow these Prior Authorization (PA) Response Timelines from receipt of PA, if complete information received:

Line of Business	Standard PA	Urgent PA
Mountain Health Trust (WV Medicaid and CHIP)	5 business days	2 business days
Commercial	5 business days	2 business days
PEIA	5 business days	2 business days
Medicare Advantage	14 calendar days	3 calendar days
Self-funded/ASO	15 calendar days	3 calendar days

If a PA request is incomplete:

- THP will notify provider of the deficiencies within 2 business of receipt.
- Provider will have 3 business days to respond with complete information.
- If provider responds within 3 days business with complete information, THP will have 2 business from receipt of complete information to render decision.
- If provider does not respond within 3 business days, the PA is denied, and a new PA request must be submitted.

If a peer review is requested, then THP must complete peer review process and render decision within 5 business days of the request.

If an official PA appeal is submitted, then THP must render an appeal decision within 10 business days from appeal submission.

The Medical Prior Authorization Requirements are available on THP's corporate website and secure provider portal.

Urgent Requests:

If services are required in less than 48 hours due to medically urgent conditions, please submit an urgent pre-service authorization.

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.

Services performed without authorization will be denied and you may not seek reimbursement from members.

eviCore healthcare

THP partners with eviCore healthcare to manage medical necessity and prior authorization for the following services for all MHT, Medicare Advantage and Commercial Fully Insured product lines.

- 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)
- Musculoskeletal Conditions
- Spine Pain Management
- Chiropractic care – the first 20 visits do not require prior authorization
- PT and OT – the first 20 combined visits do not require prior authorization

Service(s) performed in conjunction with an inpatient stay, 23-hour observation, or emergency room visit is not subject to authorization requirements.

Nurse Information Line

A nurse navigator is available 24 hours a day, 7 days a week to assist with medical management questions. However, a nurse navigator does not provide prior authorizations after normal business hours.

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 provider (PCP) or referring participating specialist with the Clinical Services 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 practitioner 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-network and tertiary non-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 Clinical Services inpatient nurse navigator to the Medical Transition of Care Team to evaluate care needs.

Concurrent review is performed by portal submission and involves communication with practitioner(s), hospital utilization review staff, social workers, and family members, as necessary.

Upon discharge from an acute care stay, all members received a follow discharge call and assessment to identify discharge planning needs. If members are identified and opt-in to a program, a referral is sent to care coordination or the Medical Transition of Care team for transitional care needs depending on risk stratification.

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 service does not warrant an expedited review. Unless an emergency, scheduling should be done after being approved by THP.

Medical Transition of Care Team

THP implemented a medical transition of care unit to aid in keeping enrollees healthy and out of the hospital. Highly driven from Utilization Management, this program focuses on early identification of enrollees that are high risk for admissions or readmissions by using our iPro admission risk score.

Enrollees can also be referred by THP staff. The goal of this program is to keep our enrollees healthy and out of the hospital while also assisting with other transition of care needs including but not limited to: exhaustion of benefits, assistance in finding in-network providers or transitioning from one plan to another. Once enrolled in the program, the member is periodically contacted for 90 days to ensure all transitional needs are met. If long term needs are identified, the member is referred to care coordination or complex case management dependent on the risk stratification.

InterQual® Review

THP utilizes Change Healthcare InterQual® criteria as a screening guideline to assist reviewers in determining medical appropriateness of health care services. Any participating 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 THP Clinical Services Department if you have a general InterQual® question or a question regarding a particular type of care.

THP uses InterQual® guidelines for most procedures and services other than for MHT where West Virginia's Bureau of Medical Services has mandated use of other criteria for specific services.

PCPs are responsible for directing care to specialty care practitioners. THP 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. Additional services may require prior authorization based on specific plan requirements of some groups. 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 THP if you have concern regarding a particular procedure or test. The prior authorization list is designed to improve communication to our provider community and to reduce administrative burden. . This 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.

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, 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 practitioner should send the report back to the referring practitioner, who will discuss findings with the member.

Specialist Coordination of Health Care Services

THP will 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 the PCP, the specialist, and the member. The treatment plan is reviewed by THP's Clinical Services Department.

Standing Referral

Ongoing care over an extended period 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 (SCA) 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.

Specialist Acting as Primary Care Provider

THP members have the right to select and change their PCP. If the member would like to request a specialist as their PCP, due to a disabling condition, the specialist practitioner must give their signed consent that they will take over the PCP responsibilities for the member.

THP has a review and approval process that must be completed before a specialist practitioner can be listed as a member's PCP. THP will require a "Request Form: Specialist as Primary Care Provider" to be completed by the member, current PCP, and specialist practitioner. The form includes information regarding the member's demographic information, current PCP information, reason for requesting a specialist as a PCP, and the information pertinent to the specialist practitioner. After confirmation of qualification through a diagnosed disabling condition, chronic illness, or SSI eligibility, reasons given for requesting a specialist practitioner as a PCP are as follows:

- The specialist is already serving as the member's PCP
- The specialist was recommended by the member's current PCP
- The specialist was requested to serve as the member's PCP

The specialist practitioner will need to supply their name, specialty, NPI, taxonomy(ies) code, practitioner practice name, practitioner office information, and the member's care history with the specialist practitioner. The practitioner will need to describe the existing relationship between the member and the specialist practitioner. This should include the time in care and which services are provided. The specialist practitioner will need to provide clinical rationale as well as any supporting documentation.

The specialist practitioner's specialty must be supplied to determine if they have the credentials to support providing PCP services. The specialist practitioner must be board certified and/or have education and training in the field of family medicine, internal medicine, general practice, pediatrics, geriatric medicine, and/or obstetrics/gynecology. The specialist practitioner must also be participating and in good standing with THP.

The specialist practitioner will attest by signature and date that they are agreeing to serve as the PCP for a specific member, and that they will fulfill all the PCP duties described in THP's provider contract, Provider Manual, and policies/procedures.

The Request Form: Specialist as Primary Care Provider can be found in THP's corporate website, healthplan.org, provider portal, myplan.healthplan.org, or by contacting THP's Customer Service department. Once the member, current PCP, and specialist practitioner complete the Request Form: Specialist as Primary Care Provider, it will be submitted to THP Medical Director for review and to approve or deny.

The completed Request Form: Specialist as Primary Care Provider, along with the applicable letters, will be sent to the member, the current PCP, and the specialist practitioner. The designation of the specialist practitioner as the PCP for the member will allow the PCP copayment to be applied for all services rendered by the specialist practitioner.

THP will grandfather any current member who has a specialist listed as their PCP in THP's system as of May 1, 2022. These members and specialist practitioner will not be required to complete the Request Form: Specialist as Primary Care Provider; however, the specialist practitioner is still required to fulfill all THP PCP requirements.

Clinical Programs

Providers may refer members to our free Member Wellness, Prevention and Health Promotion or Clinical Programs via our website at https://www.healthplan.org/providers/resources/physician-case-management-referral

Member Wellness, Prevention & Health Promotion

THP offers of primary preventive health interventions to help decrease the incidence or progression of illness and chronic disease. THP engages the member in wellness and health promotion activities, such as education, physical activity, and health screenings, to encourage a healthy lifestyle.

THP provides and promotes a health risk screening, wellness information, clinical guidelines, and other self-management tools. They are available on THP corporate website, secure member portal, or interactively by telephone with a health coach or outreach member advocate by calling 1.855.577.7124.

Member Wellness and Prevention and Health Promotion initiatives include:

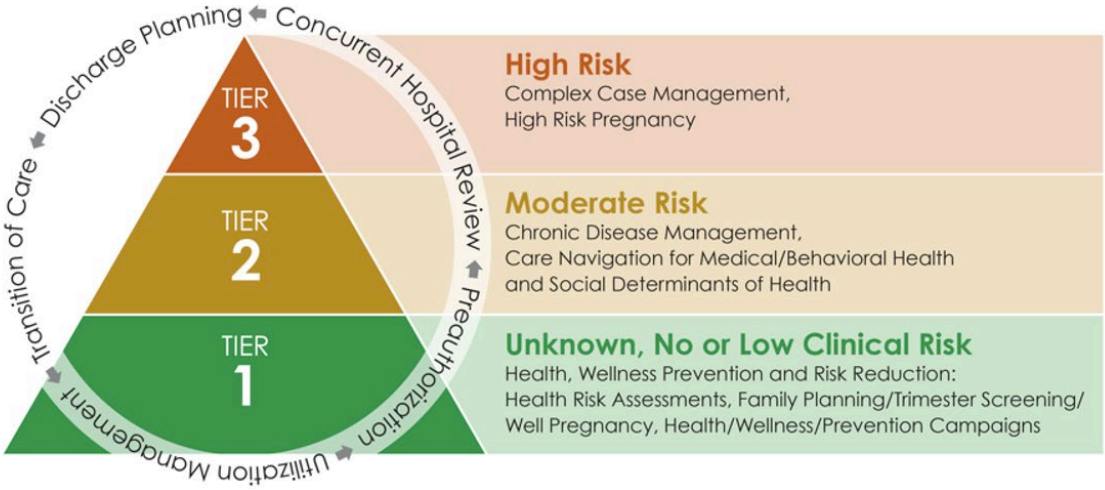
- Outreach/welcome calls
- Health Risk Screening with risk stratification to clinical program referrals
- Screening/Periodicity Reminders/Gap in Care Closure Notification and education to impact Over and Under Utilization of resources with targeted campaigns
- Family Planning Education, Trimester Screening and Well Pregnancy 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 via health fairs, wellness program, email blasts and targeted campaigns
- Personal Wellness with Certified Health Coaches providing care planning towards individualized goals through engagement in our CoreWellness Program
- Certified life coaches to assist with self-actualization, inclusive of educational resources/job training, managing finances/budgeting and assistance with family resources. The life coaches may be reached by calling 877-236-2293 Monday through Friday from 8 am to 5 pm.
- Social Determinant of Health screening and resource referrals to outside supports/community- based organizations: Women, Infants and Children (WIC), Food Banks, Birth to Three, Workforce, etc. THP Social Workers may be reached by calling 1.877.221.9295Monday through Friday from 8 am to 5pm.
- Tobacco Cessation

Care Coordination

Care Coordination is promoted through a series of supportive services and programs offered to THP members to facilitate quality care planning and improve access to care. Care Coordination is made up of a three- tiered risk-based stratification system that includes opportunities for members to engage in programs based on a Low, Moderate or High-Risk level.

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 to name a few, are appropriate to refer or may self-refer to a care coordination program. THP's clinical analytic tools and health risk assessment results are used to stratify members to a program that is correct for them. Members with high clinical risk and actionable opportunities may be appropriate for Complex Case Management or High-Risk Pregnancy if they are pregnant. Those with lesser risk but identified needs may be enrolled in Care Navigation. Members requiring specific education to manage chronic conditions such as diabetes, cardiac, respiratory, or high-risk perinatal conditions may be appropriate for Disease Management or Perinatal Care Programs. Members with low risk or unknown risks may benefit from engagement in Health and Wellness, Prevention and Risk Reduction Programs such as CoreWellness or by receiving information through an educational campaign to aid in prevention or promote wellness and routine screening.

THP Clinical Care Coordination Programs form a pyramid with high-risk members enrolled in Tier 3 Programs at the top of the pyramid and Tier 1 or Health and Wellness programs forming the base of the pyramid. Each program includes educational aspects of the information included in the programs below. For example, Complex case management includes health and wellness/preventive information as well as chronic disease management information for members with relevant diagnoses. Utilization management programs encircle the care coordination programs and provide another layer of support and service to provide access and promote comprehensive care across all settings and risk levels.



Care Navigation

Care Navigation is a program for the moderate risk 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.

Complex Case Management

The Complex Case Management Program is a service that helps provide appropriate care and supportive services to high-risk individual members, their families and/or caregivers via a personalized care plan. Members are identified as high-risk due to severity of illness or injury and complexity of services and are enrolled in this program based on a clinical analytic defined risk score comprised of clinical risk and actionable opportunities or a high score on a health risk assessment. Members receive a comprehensive HRA and/or 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 for as long as the case remains open. 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 manager 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 along with the primary care provider. Timing of interventions and call frequency is based on individual need, member acuity and agreed upon schedule of interventions.

Complex Case Examples May Include:

- Transplants—organ and bone marrow/stem cell; includes evaluations, pending and post transplants
- Catastrophic neuromuscular diseases such as multiple sclerosis, myasthenia gravis, amyotrophic lateral sclerosis
- Brain injury in active treatment
- Cystic fibrosis
- New spinal cord injury
- 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
- Immunodeficiency
- Ventilator cases in home setting
- Major congenital anomalies – atrial septal defect, valve stenosis and atresia, pulmonary artery stenosis, patient ductus arteriosus, craniofacial deformities, myelocystocele, myelomeningocele (such as spina bifida)
- Premature birth (extreme) 28 weeks or less
- Complex cancers in active treatment; with anticipated ongoing high-cost care, including myelodysplasia
- Children with special health care needs (CSHCN)
- Hemophilia
- Genetic abnormality with ongoing care, treatment, or monitoring
- Trauma – Complex needs in active treatment
- Serious and persistent mental illness as evidenced by recurrent non-substance use related psychosis or mania with multiple emergent admissions

Chronic Disease Management Program

THP'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, chronic cardiac conditions such as coronary artery disease, congestive heart failure (CHF),and chronic obstructive pulmonary disease (COPD) or asthma. The focus of chronic disease management is early identification and educational engagement with a nurse navigator for newly diagnosed or risk based members to learn life skills needed to prevent disease progression and knowledge to support self-management. THP CDM Program also uses a remote patient monitoring (RPM) vendor for additional supports for appropriate members. The RPM program is tablet based educational materials and surveys with attached digital monitoring tools that include blood pressure cuffs, pulse oximeters, scales and

glucometers as appropriate based on the member's condition for enrollment. The RPM vendor shares biometric information of concern with THP CDM staff and the provider of record.

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 elevated-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.

Members are stratified to Disease Management Programs based on the Impact Pro Population Health Category of Chronic Big Five Conditions, identified needs, moderate health risk assessment scores, a moderate clinical risk score, actionable opportunity levels, and their propensity to engage as well as members identified with newly diagnosed Chronic Big Five Conditions.

THP's Chronic Disease Managers may be reached by calling 800-776-4771 Monday through Friday from 8 am to 5pm.

Family Planning, Well Pregnancy, and High-Risk Pregnancy Programs

Family planning, well pregnancy and high-risk pregnancy programs are designed to improve access to family planning, early and routine prenatal care, improve pregnancy outcomes, reduce neonatal hospitalizations, and reduce all costs associated with preterm birth and other complications of pregnancy. This is accomplished by providing education for family or pre-pregnancy planning, perinatal education, promoting safe health behaviors, and enhancing the management of care for women identified as interested in family planning, planning for a healthy pregnancy, pregnant and well or currently identified as high-risk for premature labor and delivery. The Family Planning, Well Pregnancy and High-Risk Pregnancy Programs are administered by THP 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
- Early Identification of Substance Use Disorder in Pregnancy and Referral to Appropriate Treatment Support
- Provision of improved family planning and 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 practitioner, THP outreach program during new member welcomes or annual HRAs, Monthly Comment Files, PRSI reports, self-referral, and claims data. Practitioners are provided with a perinatal risk screening tool (PRSI) to fill out and forward to THP.
- The targeted time for enrollment of members is during pre-pregnancy planning or early in pregnancy depending upon the program of interest.
- Early pregnancy is defined as between 12 to 15 weeks gestation for the perinatal program. A telephonic assessment of the clinical and psychosocial status, including depression screening, of the member is completed by Perinatal Nurse Navigator at enrollment, during each trimester and during the postpartum period.
- Family planning members are engaged until their personal care goals are achieved, be it achieving a healthy pregnancy or obtaining appropriate birth control or family planning.
- Consideration is given to other health conditions during care planning for Family Planning, Well and High-Risk Pregnancy Programs.

- For pregnant members, the assessment tool, along with the perinatal risk screen completed by the practitioner, 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 dependent on identified risk factors. Relevant information is shared, and care is coordinated with involved providers including PCP and obstetricians throughout the program.
- 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.
- Members in well and high-risk pregnancy programs are provided with education/information and self-management tools to promote parenting and newborn care during the postpartum period. Sample educational materials are available to participating providers.

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

THP's Perinatal Program Case Managers may be reached by calling 877-236-2288 Monday through Friday from 8 am to 5 pm.

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

- Members are identified by risk level and offered the opportunity to engage in a relevant care coordination program. A Care Navigator/Nurse Navigator performs a telephonic assessment to determine the member's specific needs and opens a case.
- The member receives an introductory call and letter explaining the program. The provider receives a copy of the member letter as well.
- A plan of care is established based on the member assessment. The care plan identifies prioritized opportunities, goals, and interventions to facilitate personal goal achievement. The care plan is available on the secure member portal to the member and their designated care team members. 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.

- 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 program 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. All care coordination programs require that a member opts into the program and remains actively engaged throughout the course of the program.

Advance Care Planning

Advanced Care Planning allows for effective communication between providers and patients to plan for the patient's future care.

Provider's Role:

1. Ask each member over the age of 18 if they have an advance directive and document the answer in the member's medical record. If the member does not have an advance directive, that should be noted in the medical record, and the provider and office staff should encourage discussions with the member to help them understand advance directives and the importance of such documents. Provide them with educational material regarding advance care planning. 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.
2. Transfer any member whose advance directive you cannot support based on moral or religious beliefs that may prevent you from full support of the member's decision.

Compliance with advance directive policies is part of THP'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 THP 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.

Information regarding advance directives is provided at the time of the member's initial enrollment and is included in their welcome packet. In addition, advance directive information for all 50 states is available on THP corporate website. Information is also provided at health fairs and community events.

THP utilizes Five Wishes to provide education regarding advance care planning to all members. The document is available in print and online formats and can be provided by PMC upon request or sent to members by calling the Health Coaches at 877-903-7504 Monday through Friday from 8 am to 5 pm.

Clinical Leadership and Committees

THP's Chief Medical Officer (CMO) and medical directors 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:

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

THP's medical directors are responsible for all utilization management decisions not delegated to an outside vendor (i.e., denial of authorization decision based on medical necessity). They will communicate with primary care provider, attending practitioner, and specialist reviewers as necessary for case discussions.

THP's medical directors' other responsibilities include:

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

Physician Advisory Committee

The Physician Advisory Committee (PAC) is a collaborative committee established to receive input from the physician community to guide THP 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 THP.

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 THP; and/or (c) matters of a clinical or administrative nature that impact the interaction between physicians and THP.

In addition, physicians serving with the 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 THP 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 THP 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. THP's medical director has the final decision-making authority.

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 THP membership. The committee's composition includes practitioners, pharmacists, and representation from THP. The Pharmacy and Therapeutics Committee reports quarterly to the Quality Improvement Committee.

Quality Improvement Committee

The Quality Improvement Committee responsibilities include recommending policy decisions, analyzing and evaluating the results of QI activities, ensuring practitioner participation in the QI program through planning, design, implementation, and review, identifying needed actions and ensuring any follow-up as appropriate.

- The committee recommends and revises, or oversees recommendations and revisions to, policies for effective operations of the QI program and achievement of the QI program objectives.
- The committee oversees the analysis and evaluation of the QI program and assesses the results.
- The QI committee facilitates participating practitioner involvement in the QI program activities through attendance and discussion in relevant QI committee or QI subcommittee meetings or on ad hoc task forces.
- The committee identifies actions to improve quality, prioritizes them based on their significance and choose which to pursue, or oversees these functions if performed by an associated committee or subcommittee.

- The QI committee reviews and evaluates The Health Plan's actions to determine their effectiveness.

Credentialing Committee

The Credentialing Committee serves as the peer review committee responsible for reviewing all information available regarding provider credentials as well as character, professional competence, qualifications, and ethical standing of applicants for privileges as providers of THP. This committee is also responsible to investigate any breach of ethics reported to the committee, to propose changes or restrictions in privilege status, and to recommend or reject new appointments and reappointments.

Annual Utilization Management Program Description and Evaluation

An annual written Clinical Service UM program evaluation that includes the Medical, Behavioral Health, Pharmacy and Appeal & Grievance Units is prepared in collaboration with Clinical Service management staff. The evaluation includes data from the work plans which include barriers encountered, opportunities for improvement, final analysis, and recommendations for the upcoming year. The evaluation is complete after recommendations (if applicable) are received from the UM work group, the Continuous Quality Improvement work group and approved by the Medical Directors Oversight Committee (MDOC).

Once the UM program evaluation is finalized by MDOC the recommendations are incorporated into a revised annual UM Program Description for the upcoming year. When the updates are completed the revised UM Program Description is discussed with the UM workgroup and MDOC for recommendations.

The finalized Utilization Management Program Description is effective after the Statement of Approval is completed by the MDOC representative and the Chief Medical Officer.

Population Health

THP's population health team 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 (EHR) may also be available through shared portal access with providers. Other various data points include clinical assessments performed by THP's 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 THP service area
- Members that should be targeted for various care navigation programs
- Appropriateness for 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

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. THP is required to report quality performance measures set forth by HEDIS, to NCQA, CMS, and BMS annually.

The HEDIS audit takes place annually between January and June and administrative (claim) data is used when applicable. THP 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. THP will coordinate an onsite visit to accommodate the provider and office staff.

To support performance measurement, care gap reports to identify members with gaps in care according to HEDIS quality measures specifications are available through the secure provider portal. Gap reports are run monthly based on a proactive review of members' claim history.

Coding by measure is outlined in the Quality Measures and HEDIS Coding Guide that is available on THP's corporate website.

In addition to utilizing care gap reports and the appropriate HEDIS related ICD-10 codes to capture the services rendered, practitioners can submit clinical documentation for HEDIS measures via fax to the Population Health team at 1.304.433.8208. A documentation fax cover sheet is required and can be found on the provider portal resource library.

Introduction

The Health Plan (THP) shall promote optimal therapeutic use of pharmaceuticals by encouraging the use of cost effective generic and/or brand drugs in certain therapeutic classes.

THP has processes in place that explain how members, pharmacists, and practitioners determine which medications are covered under the members' benefit, any utilization management requirements and where members can fill medications.

1. THP publishes a prescription formulary at least annually for Commercial, Exchange, Medicare and Self-Funded/Administrative Services Only (ASO) lines of business on the corporate website, healthplan.org. The formulary indicates a drug's copay tier and utilization management requirements including prior authorization, step therapy, or quantity limit requirements.

THP has drug policy coverage criteria to encourage the use of preferred drugs in the therapeutic class for the treatment of certain diseases. THP publishes the drug policy coverage criteria for Commercial, Exchange, Medicaid and Administrative Services Only (ASO) plans on the provider portal (myplan.healthplan.org "Policies"). Drug policy coverage criteria for Medicare plans is published under Additional Resources on the Medicare portion of the website (medicare2024.healthplan.org "Quality Assurance and Utilization Management"). Select drugs require prior authorization based on specific plan requirements of some groups.
practitioners shall be informed of service and authorization requirement changes (including site of service changes) 30 days prior to the implementation of changes.

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 Food and Drug Administration (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.

THP 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. Where allowed by **Freedom of consumer choice for pharmacy** (WV House Bill 4112), 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.

TheHealthPlan

Chapter 9

Pharmacy

Provider Manual

Clinical Criteria for Pharmaceutical Management Program

THP utilizes both external clinical vendor and internal utilization management policies to perform medical necessity reviews for pharmaceuticals. Drug policy coverage criteria are developed based on reasonable medical evidence and guidelines using one or more of the following: FDA label literature, national accepted treatment guidelines, and/or standard medical reference compendia adopted by the United States Department of Health and Human Services.

Additional factors take into consideration include: individual member circumstances and medical history, West Virginia Bureau for Medical Services (BMS) Preferred Drug List, Coverage Details and Criteria/Policy Manual (for WV Medicaid policies only), preferred covered drugs for the condition, preferred formulary agents in the drug class and cost analysis.

Policies are reviewed at least annually by the clinical vendor or THP using the aforementioned development criteria and additional factors. Recommendations are reviewed by the respective Pharmacy and Therapeutics Committees.

Pharmacy and Therapeutics Committee

The Pharmacy and Therapeutics (P&T) Committee serves as an advisory committee that is responsible for providing multi-disciplinary oversight and review of new and evolving pharmaceuticals for possible inclusion in the benefit structure for THP's pharmaceutical management program. The P&T Committee also works to ensure compliance with FDA label literature, national accepted treatment guidelines, standard medical reference compendia adopted by the United States Department of Health and Human Services and state and federal regulations.

Specialty Pharmacy Program

Specialty drugs are used to treat complex, chronic conditions and/or rare diseases. Extensive management for safety and effectiveness is often needed along with dosage monitoring and adjustment for optimal treatment of the member's condition.

Specialty drugs require prior authorization to ensure appropriate utilization of the drug. Dispensing may be limited to pharmacies with specific services and distribution programs to ensure proper management and 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.

To verify if a medication is considered a specialty drug, please refer to the formulary (list of covered drugs). Specialty drug names will be followed by a "SP" for specialty drug and listed as a tier 4, 5, or 6 in the formulary.

Pain Management Program and Opiate/Opioid Management

THP 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 THP 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
- Use of more than one immediate release and one extended-release opioid

A clinical pharmacist will review the coverage review to evaluate that the opioid is being utilized in accordance with the utilization management policy. Additionally, if necessary, the member can be limited to one prescriber and one pharmacy.

Formulary medications will be preferred over non-formulary medications. Step therapy rules may be applied when reviewing a request for non-formulary medications. Also, dosing and quantities may be limited. If the prescribing practitioner does not bill THP for services, no coverage of opioids will be provided through pharmacy benefit.

Specific to WV Medicaid beneficiaries, prescribers issuing controlled substances must review the WV PDMP in accordance with Section 5042 of the SUPPORT Act prior to issuance. In the case that a prescriber is not able to check the PDMP despite a good faith effort by the prescriber, the prescriber must document such good faith effort, including the reason(s) why the prescriber was not able to check the PDMP. Prescribers may be required to submit, upon request, such documentation to Medicaid.

THP's Pharmacy Network

A THP member may obtain a prescription at any participating THP pharmacy. For the location of a participating pharmacy, call Express Scripts, THP's prescription benefit manager at 1.800.988.2262 or expressscripts.com. The member's THP ID card must be presented to the pharmacy 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.

Formulary

THP formularies are a listing of prescription medications that are preferred for use. Formulary drugs will be a covered benefit when dispensed at participating pharmacies. Non-formulary drugs are not covered without an approved coverage determination from THP. Coverage requests may be requested.

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.

Choosing a Preferred Drug Formulary

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 practitioner 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 THP cost of a brand name and its generic equivalent (i.e., THP only pays for the generic cost.) *Please note non-formulary brand versions of generic drugs require coverage review.*

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 practitioner for authorization to be granted for a specific drug. A non-formulary exception request can be made by the member, member's representative, or practitioner. A Formulary Exception Request Form may be accessed by contacting Pharmacy Services at 1.800.624.6961, ext. 7914.

THP 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 THP formulary.
2. In the practitioner'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 criteria-based programs for determining whether members qualify for coverage of a requested drug based upon the plan's drug policy coverage criteria. Drug policy coverage criteria are based on recommendations of the Pharmacy and Therapeutics Committee. These criteria are periodically reviewed for alignment with FDA label literature, national accepted treatment guidelines, Standard medical reference compendia adopted by the United States Department of Health and Human Services and state and federal regulations.

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, THP 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 pharmacy will transmit a claim to THP 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 generic.
- 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.

Pharmacy Prior Authorizations

Program Description

THP's Pharmacy Services Department handles customer service calls and coverage review determinations as well as eligibility and prior authorization updates.

THP's pharmacy prior authorization requirements can be found on THP's secure provider portal and corporate website, healthplan.org.

Traditional Prior Authorization (TPA)

THP Pharmacy Services Department adjudicates coverage review determinations and authorization updates. Traditional prior authorization criteria are developed and conform to plan coverage conditions for client review and selection and in administering prior authorization policies. Traditional prior authorization rules require coverage review for all claims presented for a given drug to determine if the member meets drug policy coverage criteria.

Smart Rules – Automated Prior Authorization Processes at the Point of Sale

Smart rules in pharmacy benefit manager's system use sophisticated logic in conjunction with available drug history, patient reported health information, and medical claims information to automatically determine whether a member qualifies for coverage of a drug based on the plan's drug policy coverage criteria. As a result, smart rules limit coverage reviews to only those claims where the member's information is least likely to meet drug policy coverage criteria.

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 most members. Drugs that are subject to quantity per dispensing event rules usually have specific quantity limitations approved by the FDA. Through traditional prior authorization, members can be approved for an additional quantity exception.

TheHealthPlan

Chapter 10

Quality

Provider Manual

Introduction

The Health Plan (THP) 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.

THP Quality Management Program consists of quality improvement strategies and the collection/analysis of data to identify and monitor for systemic issues, quality of care issues, identify opportunities for improvement through root cause analyses, and develop corrective action plans and initiatives. Once corrective action plans or initiatives are implemented, results are measured and remeasured to determine the effectiveness of actions. Modifications and adjustments are made based on data driven outcomes.

Goals and Objectives

1. Demonstrate compliance with the following:
    - The National Committee for Quality Assurance (NCQA)
    - Centers for Medicare and Medicaid Services (CMS)
    - QIarant - External Review Organization for WV Department of Health and Human Resources (DHHR)
    - West Virginia Office of Insurance Commissioner (WV OIC)
    - Ohio Department of Insurance (ODI)
2. Monitor and improve continuity of care between practitioners and across practitioner settings
3. Establish standards and processes for measuring and improving the quality of care and services provided to members through:
    - Peer Review Processes
    - Medical Record Audits
    - Member and Provider Satisfaction Surveys
    - Clinical Care
        - Medical/Surgical Potential Deviations in Care
        - Behavioral Health Potential Deviations in Care
        - Medicare Advantage, West Virginia Mountain Health Trust (West Virginia Medicaid, and WV Children's Health Insurance Program)and/or CMS driven clinical reviews which include:
            - Never Events (NE)
            - Hospital-Acquired Conditions (HAC)
            - Health Care-Associated Conditions (HCAC)
            - Provider Preventable Conditions (PPC)and other Provider Preventable Conditions (OPPC)

4. Provide a platform for members and practitioners to express concerns regarding care and service experience
    - Quality of care
    - Access to care
    - Customer Service
    - Billing/Financial Service by The Health Plan
    - Quality of practitioner office site
5. Implement initiatives to improve health care outcomes and clinical safety through the use of evidence based guidelines and resources

Clinical Care Quality Indicators

The Quality Management Department monitors quality of care concerns centered on evidence-based guidelines through a root cause analysis conducted by a THP nurse quality coordinator.

THP follows these evidence-based guidelines:

- 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

Practitioner Expectations

THP's Quality Improvement Committee (QIC) identified the following expectations and behaviors for all THP participating practitioners:

This cooperation includes collection and evaluation of performance measurement data and participation in Quality Improvement programs. THP may use performance data for quality improvement activities.

Additional requirements include cooperation with potential quality of care root cause analyses, member complaints/grievances, or any other review or reporting requirement including state or federal agency with authority, the National Committee for Quality Assurance (NCQA), Healthcare Effectiveness Data Information Set (HEDIS), or any other data collection requirement.

Practitioners are expected to cooperate in a timely manner in any of the Quality Improvement activities requested by THP.

THP is responsible for implementing procedures for reducing, suspending, or terminating a practitioner's participation for reasons relating to quality of care, competence, or professional conduct. Remedial action plans will be developed within thirty days of identification of the systemic problem. Corrective Action Plans may be instituted for any treatments, procedures, or services which indicate a practitioner is not practicing medicine in a manner that is keeping with reasonable and prevailing standards of care or medical ethics. This may be identified through complaints, QI activities, failure to maintain adequate medical records, failure to provide adequate care or after hours care, or any other occurrence leading to quality of care issues.

Corrective actions may vary according to the situation and may include but are not limited to, one or more of the following as they relate to treatment, procedure, and service:

- Written warning to the practitioner
- Discussion with the practitioner
- Placing the practitioner under a focused review via medical review or reviews generated by claims data at scheduled intervals; results reported to the Quality Improvement Committee (QIC) who will direct further action of the corrective action plan
- Requiring the practitioner to enter into a preceptor relationship with another practitioner, whereby the practitioner acting as the preceptor would monitor and observe the practitioner subject to corrective action, including examining medical records and interaction with members
- Requiring the practitioner to complete continuing medical education regarding treatment, procedure, or service in question
- Limiting the practitioner's privileges (i.e., limiting the authority to perform certain procedures)
- Recommendation for recredentialing on a shorter cycle
- Recommendation for contract termination

Any final determination resulting in corrective action will be communicated to the practitioner in writing, setting forth the type and nature of the corrective action to be taken. Any corrective action will be monitored for compliance at intervals determined by the Quality Improvement Committee. The practitioner will be notified of the results of such monitoring and will be made aware of the termination or continuation of any corrective action as recommended by the Quality Improvement Committee.

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, provides access to all biographical and medical information, and promotes quality care.

All participating practitioners shall maintain a current member medical record in accordance with THP standards for patient records and shall comply with all federal and state laws and regulations.

All practitioners shall preserve all records related to members for a period of not less than ten (10) years and retain records longer if the records are under review or audit.

The medical records shall be made available, as required, to each practitioner treating the member. Medical records will be made available upon request to an authorized representative of THP for medical audit, utilization review, fiscal audit, and other periodic monitoring.

All medical records and patient information should only be accessed to complete job duties; discussion outside of normal job duties is strictly prohibited and should be kept confidential.

Members have the right to approve or deny the release of identifiable personal health information by the practitioner except when required by law. Member information shall not be released without signed authorization.

- 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 computers 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 or burning.

All practitioner offices should require review of the medical record and confidentiality statement, annually.

Standards for Patient Records

1. THP requires consistent and legible method of record keeping for all patient encounters. Each patient's medical record entry must comply with the following medical record documentation standards:

    - Must be easily readable
    - Information needed to conduct utilization review
    - Member/Beneficiary identification information: Name or identification number on each page or electronic file
    - Personal/biological data: age, sex, address, employer, home and work phone number, and marital status
    - Entry date
    - Practitioner identification
    - Allergies
    - Past medical history
    - Immunizations (for members aged 12 and under there is a completed immunization record or notation that immunizations are up-to-date, and when subsequent immunizations, if any, are required
    - Diagnostic information
    - Medication information
    - Identifications of current problems: significant illness, medical conditions, and health maintenance concerns
    - Smoking/ethanol/substance use notation concerning cigarette and alcohol use and substance use is present for patients 14 years and over and seen three or more times
    - Consultations, referral, and specialist reports: notes from consultations, lab, and x-ray reports with the ordering practitioner's initials or other documentation signifying review, explicit notation in the record and follow up plans for significantly abnormal lab and imaging study results
    - Emergency care
    - Hospital discharge summaries: all hospital admissions which occur while the member is enrolled in the plan, and prior admissions as necessary
    - Advance directives: documentation of whether the member has executed an advance directive
    - Visit data of individual encounters must provide adequate evidence of, at a minimum:
        - History and physical examination, including appropriate subjective and objective information for the presenting complaint
        - Plan of treatment
        - Diagnostic tests
        - Therapies and other prescribed regimens
        - Follow up, including encounter forms with notations concerning follow up care, or visits; return times noted in weeks, months or as needed; unresolved problems from previous visits are addressed in subsequent visits
        - Referrals and results thereof
        - All other aspects of care, including ancillary services

2. Medical records must be legible, meaning the record is legible to someone other than the writer. Any record judged as illegible will be evaluated by a second reviewer.
3. Medical records must be available and accessible to THP and to appropriate state and federal authorities, or their delegates, involved in assessing the quality of care or investigating member grievances or complaints
4. THP ensures appropriate and confidential, privacy protected, exchange of information among practitioners
5. THP ensures that the identification and assessment of member needs are promptly shared with the State, other MCO's and private insurers and makes all efforts to prevent duplication of these activities
6. THP has a process to assess and improve the content, legibility, organization, and completeness of member health records through an annual medical record audit and comprehensive analysis. Practitioners whose medical records do not meet the thresholds will be notified of the audit findings and will be provided with additional educational resources and/or remediation plan if warranted. This process is followed for other QAPI activities that may require a medical record to be reviewed.

Those with medical record audit finding may be placed on a focus review as determined by the Quality Management Director, Medical Director, or Quality Improvement Committee. Focus reviews related to medical record audit finding will be directed by the Quality Improvement Committee, the Executive Management Team or The Health Plan Board of Directors will be conducted as instructed.

Electronic Health Record (EHR)

Technical Specifications

The office has a policy/procedure such as a backup system to prevent loss or destruction of EHR.

EHR Health Information Exchange

The office has a policy/procedure to ensure secure, authorized electronic exchange of patient information.

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.

Auto-populations Information or Defaults

The office has a policy/procedure to verify the validity of auto-populated information. Auto-populated information or defaults refers to data that does not require a positive action or selection, or data that is entered by abbreviated words or keystrokes.

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.

E-prescribing

For offices currently utilizing E-prescribing, they have a policy/procedure for monitoring to prevent fraud, waste, and abuse.

Continuity and Coordination of Care

THP supports and guides the partnership of members and primary care practitioners to ensure continuity and coordination of care. THP's continuity and coordination of care policy specifies the following responsibilities:

- All practitioners involved in a member's care must share clinical information with each other and the member timely. Most referrals to specialty care should be submitted by the PCP. Treatment plans should specify an adequate number of direct access visits to specialty care to accommodate the treatment plan's implementation. Members are afforded direct access to behavioral health practitioners. All referral notifications will include a reminder to all parties to share clinical information timely.
- Practitioners must document member input in all treatment plans submitted;
- THP does not prohibit a health care professional from advising and advocating on behalf of a member.
- Practitioner 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.

Practitioner Availability Standards

Primary Care Provider (PCP) and Practitioner Expectations:

- Maintain continuity of enrollee's health care by serving as the PCP
- Provide access twenty-four (24) hours a day, seven (7) days a week
- Emergency cases must be seen immediately or referred to an emergency facility
- Urgent cases must be seen within forty-eight (48) hours
- Routine cases other than clinical preventive services, must be seen within twenty-one (21) calendar days (exceptions are permitted as specific times when PCP capacity is temporarily limited)
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services must be scheduled in accordance with EPSDT guidelines and the EPSDT Periodicity Schedule
- 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
- Follow THP's established procedures for coordination of in-network and out-of-network services for Mountain Health Trust enrollees
- Have one (1) or more THP participating practitioner(s) as back up coverage to be available by phone or answering service.
- Required to notify THP if they are no longer accepting new patients provide a minimum of 20 hours per week of patient care availability

Screening for Behavioral Health Needs

THP encourages PCPs to assess members for behavioral health needs. Screenings should be provided to people of all ages. If you need assistance with a referral to a behavioral health specialist contact THP's Behavioral Health Department at 1.877.221.9295 for assistance.

THP's suggests the following when encountering patients who may be experiencing problems with substance use disorders.

- Ask about substance use and screen for problem use.
- List the patient's diagnosis in the medical record.
- Refer to a qualified behavioral health clinician, when necessary
- Encourage the patient to follow through.
- Express interest in their progress.

Practitioner Self Care/Treatment and/or Family Care/Treatment

THP follows American Medical Association (AMA) recommendations that practitioners should not treat themselves, their immediate family members, or their household members.

Practitioner should not treat themselves or members of their families.

However, it may be acceptable to do so in limited circumstances such as:

- In emergency settings or isolated settings where there is no other qualified practitioner available
- For short term, minor problems
- Except in emergencies, it is not appropriate for practitioners to write prescriptions for controlled substances for themselves or their immediate family members

When treating self or family members, practitioners have a further responsibility to document treatment or care provided and covey relevant information to the patient's PCP.

Access Standards

Primary Care Providers (PCP)	
Routine Care	Within 21 calendar days
Urgent Care	Within 48 hours
Emergent Care	Immediately or referred to an emergency facility
Behavioral Health	
Initial Routine Care	Within 10 business days
Follow Up Routine Care	Within 30 business days (prescribers) Within 20 business days (non-prescribers)
Non-Life-Threatening Emergency Care	Within 6 hours
Emergent Care	Immediately or referred to an emergency facility
OBGYN	
Initial Prenatal Care	Within 14 calendar days of the date the patient is found to be pregnant
Initial or Follow Up Routine Care for Non-OB Patients	Within 30 calendar days
Specialty Care	
Initial Routine Care	Within 30 calendar days
Follow Up Routine Care	Within 30 calendar days

After Hours Accessibility

Practices should be available to the THP members through on call practitioner, answering service, or voice mail message directing the member to the Emergency Room if the case is emergent.

TheHealthPlan

Chapter 11

Credentialing

Provider Manual

Credentialing

The Health Plan (THP) is National Committee for Quality Assurance (NCQA) accredited and is required to comply with NCQA standards. In addition, THP is required to comply with the states of West Virginia and Ohio, West Virginia Mountain Health Trust (MHT) and Centers for Medicare and Medicaid Services (CMS) credentialing guidelines. For practitioners to provide services to THP MHT members they must enroll with Medicaid Management Information System (MMIS), the state of West Virginia's fiscal agent, prior to providing service(s).

THP requires practitioners to comply with the requirements of all applicable federal, state, and/or local law, rules, regulations, and standards, including but not limited to licensure, certification, accreditation, and/or registration requirements. It is the practitioner's responsibility to determine the legal requirements with which the practitioner must comply. THP reserves the right to take any action it deems appropriate, including but not limited to termination of a practitioner's contract, termination of other rights and/or privileges for a practitioner, denial of claims submitted by a practitioner, and/or recouping payments previously made to a practitioner, for a practitioner's failure to comply with applicable law, rules, regulations, and standards.

An established process is followed to credential practitioners. Information submitted to THP as part of the credentialing process is verified as outlined below. Applicants and their practices are reviewed using certification standards developed and approved by THP's practitioner committee. THP's credentialing and recredentialing is conducted in a non-discriminatory manner. THP does not discriminate regarding network participation or reimbursement against any practitioner who is acting within the scope of their license or certification.

Initial Credentialing

- The initial credentialing process includes completion of The Council for Affordable Quality Healthcare's (CAQH) online application with primary source verifications, and if applicable, an onsite office site visit. Practitioners must authorize THP to access CAQH data.
- Primary source verification of (but not limited to):
    - Active Licensure in state where services are provided
    - Clinical Privileges at a participating THP hospital
    - Active DEA in the state where services are provided
    - Five-year work history
    - National Practitioner Data Bank (NPDB)
    - Board certification(s)
    - Medical education and training
- An on-site office site visit will be completed on the following practitioner types who service THP Commercial and/or MHT members (unless the provider has joined an office that has previously completed a THP site visit):
    - Primary Care Providers (PCP)
    - Obstetrics/Gynecology (OB/GYN)
    - Behavioral health providers
    - High volume/high impact specialties

Recredentialing

THP recredentials practitioners according to the guidelines set forth by NCQA, the states of West Virginia and Ohio, West Virginia Mountain Health Trust (MHT) and CMS. THP also reviews quality of care and member complaints at the time of recredentialing. Practitioners are credentialed at least every 36 months.

Practitioner's Credentialing and Recredentialing Rights

Right to Review Credentialing/Recredentialing Information

The practitioner has the right to review information submitted in support of the credentialing/ recredentialing application. If you wish to review the information, please call THP Credentialing Department at 1.800.624.6961 . Within thirty (30) days of the request, THP will send, by certified mail, a copy of the credentialing application and primary source verification documents received during the most recent credentialing/recredentialing cycle. The practitioner will not have access to protected peer information, references, or recommendations.

Right to Correct Erroneous Information

The practitioner can correct erroneous information. Any omissions, inconsistencies, or erroneous information that is discovered during primary source verification processes will require further investigation to determine if one or more of the following actions is needed:

- Submit to THP Medical Director for review
    - Request additional information, in writing, from the practitioner. Corrections can be submitted to THP Provider Data Quality (PDQ) team at pdq@healthplan.org.

If written response is not received within fifteen (15) calendar days, a credentialing representative will contact the office via email or phone. If response is not received after the additional fifteen (15) days, the file will become inactive, and the practitioner will be notified by letter.

Once all information is received, the practitioner will be notified via email, fax, or telephone. THP documents receipt of corrected information in the practitioner's credentialing/recredentialing file. 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.

Right to be Informed of Credentialing Status

The practitioner can, upon request, be informed of the status of their credentialing or recredentialing application. The information that will be afforded to the practitioner includes one of the following:

- Application in process
- Application pending to the Credentials Committee
- In review by THP's medical director

The practitioner may request status by contacting THP Credentialing Department at 1.800.624.6961. The practitioner will be contacted by phone or e-mail with the response to their request for application status within five (5) business days of request.

Standards for Participation

To join THP's provider network , a practitioner must meet the standards of participation as developed by THP.

A practitioner must have the following credentials:

- Active Drug Enforcement Administration (DEA)certificate for each state(s) the practitioner practices if the scope of practice would warrant the practitioner to have a DEA
- Professional liability – minimum amount of $1 million, any amount below minimum will be reviewed by the Credentials Committee
- Privileges at a THP participating hospital
- Board-certified or board eligible. If not board-certified or board-eligible, the practitioner must demonstrate appropriate training for specialty listed
- Partially executed and dated THP practitioner agreement or evidence of the intent to join under an a fully executed group provider agreement.
- Office site visit for primary care providers (PCP), OB/GYN, , and those providers designated by THP as a high-volume/high impact specialist who provides service to Commercial and/or Mountain Health Trust members.
- Active and current state medical license(s) for each state(s) the practitioner practices
- Sufficient information concerning any malpractice history
- NPI 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 with a current dated attestation
- Physician extenders practicing under a collaborative/supervising practitioner will be credentialed only if the collaborating/supervising practitioner is fully contracted and credentialed with THP.

THP Eligible Practitioner/Providers:

- Doctor of Medicine (MD)
- Doctor of Osteopathic Medicine (DO)
- Doctor of Podiatry (DPM)
- Doctor of Dental Surgery (DDS)
- Doctor of Chiropractic (DC)
- Audiologist (AUD)
- Certified nurse practitioner (CNP)
- Certified nurse midwife (CNM)
- Physician Assistant (PA)
- Independent physical therapist
- Optometrist (OD)
- Licensed psychologist
- Clinical licensed social worker (LICSW)
- Independent speech language pathologist
- Registered dietitian, diabetic educator, and nutritionist
- Licensed Professional Counselor (LPC)

THP Eligible Provider/Facilities THP:

- Ambulance provider
- Hearing Aid Dispensers
- Right From the Start (RFTS)
- Free Standing Imaging Facilities
- Ambulatory surgery centers (ASC) – must be accredited
- Dialysis Centers
- Federally qualified health centers (FQHC)*
- Rural health clinics (RHC)*
- Home health (HH)
- 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 (SNF)
- Behavioral health facilities – must be accredited
- Durable medical equipment (DME) – must be accredited and possess a surety bond; if applicable

THP requires credentialing of all independently licensed behavioral health practitioners including those practicing within a Licensed Behavioral Health Center (LBHC), Rural Health Clinic (RHC), and Federally Qualified Health Center (FQHC).

Ohio 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 email or certified mail.

The agreement will not be executed by THP until the credentialing process has been completed and approved.

Notification of acceptance and or rejection will be sent within sixty (60) days of the credentialing decision. THP will complete the credentialing process within ninety (90) days of receipt of a complete application.

Provider Data Changes

Providers should submit the following data changes to THP no less than forty-five (45) calendars day in advance. THP's provider portal resource library at myplan.healthplan.org, contains the forms needed to make updates to the following:

- Practice updates i.e., moved or closed a location
- Provider updates i.e., name change
- Provider Terminations
- Remittance and/or Billing updates
- Submit completed form(s) to Provider Data Quality (PDQ) at pdq@healthplan.org.

TheHealthPlan

Chapter 12

Compliance

Provider Manual

Provider Reimbursement

Providers must inform members non-covered services costs prior to rendering non-covered services. Providers may not bill or collect any payment from members for care that was determined not medically necessary. Providers may not balance bill members.

Providers are prohibited from collecting copays for missed appointments. Members are held harmless for the costs of all covered services provided, except for any cost-sharing obligations.

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

THP does not discriminate against providers acting within the scope of their license and shall not face discrimination with respect to participation, reimbursement, or indemnification. 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.

THP may not make specific payments, directly or indirectly, to a practitioner or practitioner 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.

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

Fraud, Waste and Abuse Regulations and Guidelines

Fraud, Waste, and Abuse (FWA) Policies and Related Laws

The Health Plan's (THP) fraud, waste, and abuse policies were established to prevent, detect, and correct fraudulent, wasteful, or abusive practices perpetrated by employees, members, practitioners, and facilities, including provider facilities not contracted with THP. Compliance with these policies is the responsibility of every employee and anyone providing services to THP members.

Providers should ensure that all staff are thoroughly educated on state and federal requirements and that appropriate compliance programs are in place. THP expects its first tier, downstream, and related entities (FDRs), its West Virginia Medicaid and West Virginia Children's Health Insurance Program (CHIP) Subcontractors, and its contracted providers to operate in accordance with all applicable federal and state laws, regulations, and Medicare Advantage and West Virginia Mountain Health Trust (MHT) (including WV Medicaid, 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 healthcare benefit program or to obtain by false or fraudulent pretenses, representations, or promises any of the money or property from a healthcare 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 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 Statue (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 Medicaid. 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, imprisonment for up to five years, civil monetary penalties, and exclusion from participation in federal health care programs.

5. **The Beneficiary Inducement Statue (42 U.S.C § 1128A(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") Statue (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 or Medicaid overpayment. Consequently, a health care provider may violate the FCA if it conceals, improperly avoids, or decreases an "obligation" to pay money to the government.

FWA Reporting

THP's 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 non-compliance, call the hotline at 1.877.296.7283. THP 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.

Special Investigations Unit (SIU)

MHT and Medicare Advantage guidelines require THP to implement an effective program to prevent, detect, and correct fraud, waste, and abuse. THP values its relationship with providers and recognizes the importance of providing valuable care to the community. THP 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 THP's network and its members, and ensuring compliance with federal regulations.

THP's SIU plays a vital role in detecting, preventing, and correcting fraud, waste, and abuse, ensuring payment integrity, and 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, the case 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.

Medical records are reviewed by the SIU, using national published guidelines from various sources which may include, the American Medical Association, American Academies, and the Centers for Medicare and Medicaid Services.

Network providers are contractually required to provide member medical records to THP upon request and within a reasonable period. Subject to the volume of records requested, the SIU routinely specifies fifteen (15) calendar days is a reasonable period of time. Failure to submit the requested records within the stated time may result in an adverse impact on payment of future claims.

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.

THP is committed to promoting payment integrity across all lines of business. In furtherance of this objective, the 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 its own efforts to ensure payment integrity or at the direction of THP 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 its 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 occurred;
2. An 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 developed 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 self-audit, the universe of claims to be reviewed and how that universe was determined, a deadline for audit completion, and instructions on how to remit any overpayments. Overpayments made under any federal health insurance program must be recovered. Refer to **Chapter 3 - Claims**, in this manual for timelines and processes related to overpayment recoveries.

The self-audit results will be reviewed by THP. The SIU may review documentation to validate the results and/or may meet with the provider or its 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.

SIU Corrective Action Plan (CAP)

Upon completion of a retrospective payment review by the SIU, if severe, complex, or numerous deficiencies are identified resulting in overpayment--though not sufficient to warrant other actions required for suspected fraud or abuse--it may be appropriate to institute a corrective action plan (CAP). A CAP is a step-by-step plan of action to help achieve desired outcomes by ensuring all outstanding issues or deficiencies identified through the SIU's review process have been addressed and corrected by the provider. During this collaborative process, the provider will be notified in writing of those issues identified by the SIU and requested to submit a self-developed, CAP on how the deficiencies will be addressed. The CAP is required to be submitted to THP within 30 days of the date of the notice. Within the CAP, the provider should list the effective date the corrective action occurred or will occur for each identified discrepancy. Upon receipt and acceptance of the corrective action plan by THP, the provider will be given reasonable times to make the corrections outlined within the plan. Additional review or audit by the SIU may be conducted (typically within 90 days of acceptance of the CAP) to assess compliance and effectiveness of the CAP. Additional reviews may be conducted, as needed, until the identified discrepancies have been adequately addressed.

Compliance Provider Training Programs

THP prepares the following education programs to encourage compliance. THP also issues provider communications to facilitate preventative actions.

1. Fraud Waste Abuse (FWA)

All practitioners and staff members 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.

- Practitioners are not required to send attestation to THP, although must maintain evidence of training for at least ten (10) years. This may be in the form of attestations, training logs, or other means sufficient to document completion of these obligations.

2. Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) Model of Care (MOC)

Annual D-SNP Model of Care training is required for Medicare Advantage practitioners and out of network practitioners that render care to D-SNP enrollees. Training and attestation are located on the secure provider portal.

3. Cultural Competency, Implicit Bias, and Social Determinants of Health (SDoH)

To ensure that providers provide services in a culturally competent manner, THP developed cultural competency and social determinants of health (SDoH) provider education. THP's Cultural Competency/Social Determinants of Health Training is available on THP's secure provider portal Resource Library. THP's Practice Management Consultants (PMC) are available for individualized education sessions.

4. Motivational Interviewing

To ensure staff and practitioners establish a respectful stance with patients, coworkers, etc. with a focus on building rapport in the initial stages of the relationship. Motivational interviewing has observable practice behaviors that allow practitioners to receive clear and objective feedback from a consultant or staff member.

Examples of Motivational interviewing elements:

- Partnership – Helping people change
- Acceptance – Understanding a person's experiences and perspectives
- Compassion – Promoting a person's wellbeing and expressing empathy
- Plan – Organizing a plan based on a person's insights
- Engage – Listening carefully and acknowledging strengths

To request any of the above as an individualized training session, please contact your PMC. Otherwise, please visit THP's provider portal Resource Library for training materials.

Compliance Through Reporting

THP 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 able to mitigate or resolve the problem. This obligation applies to all THP's first tier, downstream, and related entities (FDRs), MHT Subcontractors, and contracted providers.

THP 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, THP provides various reporting resources including 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.
- THP has adopted and requires all FDR, Subcontractors, and providers 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 Advantage, West Virginia Medicaid, West Virginia Children's Health Insurance Program (WV 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. THP, its FDRs, Subcontractors, and contracted 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 THP Medicare Advantage 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 General Service Administration's 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): https://sam.gov/content/exclusions

- In the event any employees or downstream entities are found on either of these exclusion lists, they must be immediately removed from work related directly or indirectly to THP's Medicare Advantage and MHT programs. You must also notify THP of the finding.
- Practitioners 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.

HIPAA Privacy and Security

THP is committed to ensuring the confidentiality, integrity, and availability of our members' protected health information, or PHI. PHI includes individually identifiable information that relates to an individual's past, present, or future health care or payment for health care whether in written, spoken, or electronic form.

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that requires covered entities such as THP and healthcare providers to:

- Properly secure PHI (physically and electronically)
- Protect the privacy of member/patient PHI
- Abide by the "minimum necessary" standard for the use and disclosure of member/patient PHI
- Address members'/patients' rights for the access, use, and disclosure of their 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
- Members'/patients' rights to obtain electronic copies of their electronic health record
- Makes business associates directly liable for compliance with certain HIPAA provisions
- Increased fines and penalties for violations, including civil penalties, criminal penalties, and imprisonment

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 intended recipient
- 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.

THP has implemented HIPAA-related training for all 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 corporate website, healthplan.org using the links "HIPAA Notice of Privacy Practices" and "HIPAA Privacy Information and Forms."

Resources:

1. U.S. Department of Health and Human Services- Office for Civil Rights (OCR):

   https://www.hhs.gov/ocr/index.html

2. HIPAA Frequently Asked Questions for Professionals (FAQs): **hhs.gov/hipaa/for-professionals/faq**
3. Heath Care Compliance Association (HCCA): **hcca-info.org**
4. Society of Corporate Compliance and Ethics (SCCE): **corporatecompliance.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**
8. Compliance Guidance for Individual and Small Group Physician Practices: **oig.hhs.gov/authorities/docs/physician.pdf**
9. General Compliance Program Guidance: **https://oig.hhs.gov/compliance/general-compliance-program-guidance/**
10. Health Insurance Portability and Accountability Act (HIPAA): **hhs.gov/hipaa/for-professionals/index.html**
11. Stark Law (Physician Self-Referral):

    cms.gov/Medicare/Fraud-and-abuse/physicianselfreferral/index