



# ProviderFocus

A Publication of The Health Plan • June 2019

## Provider Practitioner Manual

The Provider Practitioner Manual is updated bi-annually in July and December and may be accessed on The Health Plan's website at [healthplan.org/providers/resources/provider-manual](http://healthplan.org/providers/resources/provider-manual). 🍏

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## The Health Plan (THP) Announces Partnership with West Virginia University Health Systems (WVUHS)

The Health Plan and West Virginia University Health Systems (WVUHS) have joined to form a new, fully-integrated healthcare network.

The Health Plan and WVUHS signed a letter of intent on May 1, 2019 and the specific terms of the partnership are subject to the approval of the boards of both organizations. The goal of this new partnership is to improve the health of all West Virginians by providing access to a highly coordinated, seamless, and quality system of care in the most efficient and affordable manner possible. The Health Plan will continue to operate as a not-for-profit community health organization focused on West Virginia, northeastern Ohio, and the United States. We will maintain the same management structure, benefit structure, and commitment to providers as we do today, and function as a separate company. Our board of directors will include both WVU and THP members. The Health Plan will continue to build collaborative, value-based partnerships with other health systems and independent providers in West Virginia, just like we always have. 🍏



# Substance Use Disorder (SUD) Waiver

## Behavioral Health

Beginning July 1, 2019 the following services housed under the Substance Use Disorder (SUD) Medicaid Section 1115 Waiver will transition to managed care:



- All residential services
- Peer-to-peer recovery
- Naloxone administration by ambulance transport

Methadone is not transitioning to managed care and will remain under the fee-for-service program.

The Health Plan will be following ASAM® criteria. This information may be accessed in Chapter 504 of BMS's Provider Manual contained within the following website: <https://dhhr.wv.gov/bms/Pages/Chapter-504-Substance-Use-Disorder-Services.aspx>

Providers will follow The Health Plan's behavioral health preauthorization requirements which are located at [myplan.healthplan.org](http://myplan.healthplan.org)

In order to participate in the WV Medicaid Program and receive payment from The Health Plan, providers of SUD Waiver Services must meet all enrollment criteria which is described in Chapters 300 and 504 of BMS' Provider Manual. 🟢

## Medical Management/Behavioral Health Review Criteria

Nationally-recognized clinical criteria is utilized to perform reviews for medical appropriateness. This allows for consideration of the needs of the individual members, their circumstances, medical history, and availability of care and services within The Health Plan network. Annually, or as needed, input is sought in the review of criteria from physicians participating in the Physician Advisory Committee.

The Health Plan utilizes Change Healthcare InterQual® criteria as a screening guideline to assist the nurse reviewers with respect to medical appropriateness of health care services, including behavioral health criteria used in an active clinical review process of a procedure requiring the use of InterQual®.

InterQual® may be utilized to assist in the review of admissions, as well as surgical and radiological procedures including, but not limited to, MRI, MRA, CT scan, hysterectomy, ECT and psychological testing.

You may call The Health Plan Clinical Services Department at 740.695.7643 or 1.800.624.6961, ext. 7643 if you have a general InterQual® question or a question regarding a particular case. InterQual® review worksheets are available upon request.

Please indicate if your request is emergent so that we may expedite the review. Simply scheduling the testing/procedure does not warrant an expedited review.

Unless it is an emergency, scheduling should be done after being approved by The Health Plan. 🟢

## Member Rights and Responsibilities

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

# PT/OT Services for Members with Autism

Now Managed by Palladian Health

Medical necessity review and prior authorization for physical therapy and/or occupational therapy services for members with an Autism diagnosis will be managed by Palladian Health effective July 1, 2019. Initial evaluations do not require pre-authorization and members may self-refer for evaluation.

The following ICD-10 codes are grouped under pervasive developmental disorders and are included in this announcement:

- F84.0 Autistic disorder
- F84.2 Rett's syndrome
- F84.3 Other childhood disintegrative disorder
- F84.5 Asperger's syndrome
- F84.8 Other pervasive developmental disorders
- F84.9 Pervasive developmental disorder, unspecified

Medical necessity review and prior authorizations may be completed through The Health Plan online portal, [myplan.healthplan.org](http://myplan.healthplan.org), via fax at 1.844.681.1205, or by phone at 1.877.244.8514.

If you have questions about this new process, call us at 1.877.847.7901 or contact your provider engagement representative. 🍏



## Keep Provider/ Practice Information Up-To-Date

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

The Health Plan has instituted a feature on our website to assist providers in verifying and updating information. It is located on our website at [findadoc.healthplan.org](http://findadoc.healthplan.org). After searching your name, view the provider details on file. Click the Verify/Update Practice Info button to submit corrected information or verify that the listed information is current and correct. 🍏

## REMINDER: CMS Annual Training

Compliance and FWA training should be completed on an annual basis. Training may be completed through your own internal compliance program or by using training documents provided by The Health Plan. Training should be completed within 90 days of the initial hire date or the effective date of contracting and at least annually thereafter. You are required to maintain evidence of training for 10 years. This may be in the form of attestations, training logs or other means. 🍏

## REMINDER: Prior Authorizations

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

## West Virginia Family Health (WVFH)

# WVFH Member Transition

West Virginia Family Health (WVFH) will no longer be participating in the Medicaid program with the Bureau for Medical Services (BMS) effective July 1, 2019. As such, current WVFH members will be transitioned to another managed care organization between May 1 and July 1.

These former WVFH members will have a 90-day transition period whereby The Health Plan (THP) will honor the prior authorizations for services already granted to WVFH. BMS will share those prior authorizations with THP and the list will be used during the transition phase for medical and claims processing.

The Health Plan's prior authorization lists for medical and behavioral health services are located on the provider portal at [myplan.healthplan.org](http://myplan.healthplan.org). New services and procedures requiring authorization by THP must be requested PRIOR to performing the service or procedure. To avoid claim denials, please remember to verify eligibility at each visit.

Questions may be directed to the provider engagement representative for your county. Visit [myplan.healthplan.org](http://myplan.healthplan.org) to view the territory map or contact customer service at 1.888.613.8385. 🍏

## Complete Your DSNP Training

### For a Chance to Win a Free Lunch

Congratulations to the office staff of Marietta Memorial Hospital's Physical Therapy Department for completing their DSNP training and winning lunch delivered by The Health Plan. If you provide services to members with The Health Plan's dual-eligible special needs plan (D-SNP), you are required to complete annual training by the Centers for Medicare and Medicaid Services (CMS). Each quarter The Health Plan will draw a

winner from the providers that have completed and attested to their DSNP training to receive a catered lunch.

You may view a DSNP training presentation and attest to the training by logging into your account on our secure provider website, [myplan.healthplan.org](http://myplan.healthplan.org), or by contacting your provider engagement representative. 🍏

## Change in Preventive Medicine Reimbursement for Medicare Members

The Health Plan has enhanced the Medicare benefit for SecureCare HMO, SecureChoice PPO and Dual Eligible Special Needs Plan (DSNP) members to permit billing and reimbursement for preventive visits for Medicare members. Providers billing CPT code 99387 (initial comprehensive preventive medicine evaluation and management)

and CPT code 99397 (preventive medicine reevaluation and management) will be reimbursed at the same rate as CPT code 99203 (evaluation and management of a new patient) and 99213 (evaluation and management of an established patient). Please direct any questions to 1.877.847.7907. 🍏

# DEA/Buprenorphine Waiver Training

## Seven Informational Sessions

The Health Plan is collaborating with the West Virginia Department of Health and Human Resources, Marshall Health, West Virginia School of Osteopathic Medicine, and West Virginia University to promote DEA/buprenorphine waiver training through the American Society of Addiction Medicine (ASAM®). ASAM® is hosting seven free training sessions throughout the state of West Virginia for physicians, nurse practitioners, and physician assistants interested in attaining their DEA/buprenorphine waiver for medication-assisted treatment of patients with opioid use disorder.

West Virginia University – subject to the availability and restriction of funds – is offering a financial incentive payment for physicians, NPs, and PAs who successfully become waived. The financial incentive payment is not affiliated with The Health Plan; this information is shared for informational purposes only. Please do not contact The Health Plan regarding this financial incentive payment.

The Health Plan strongly encourages utilizing these free training opportunities and incentives while they are available. Visit [myplan.healthplan.org/Home/ResourceLibrary/Provider/](https://myplan.healthplan.org/Home/ResourceLibrary/Provider/) for more information. 🍏

## Qualified Medicare Beneficiary (QMB) Program

# Low Income Medicare Beneficiaries

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

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

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

1.800.MEDICARE (1.800.633.4227). 🍏

# The Health Plan Affirmative Statement

## Regarding Incentives 2019

The Health Plan bases its decision making for coverage of healthcare services on medical appropriateness utilizing nationally recognized criteria. Incentives are not offered to providers or employees of The Health Plan involved in the review process for issuing non-authorization nor does The Health Plan specifically reward, hire,

promote, or terminate practitioners or other individuals for issuing denials of coverage. Also, no incentives are given that foster inappropriate under-utilization by the provider, nor does The Health Plan condone under-utilization, nor inappropriate restrictions of healthcare services. 🍏

# Continuity and Coordination of Care

The goal of continuity and coordination of care is the seamless transition of patient care from one setting to another. It includes all aspects of a member's care and all of the providers involved in that care. The primary care physician (PCP) is the most appropriate connector. A member's communication with their PCP will enhance their overall health and enable the PCP to direct their care so that all appropriate medical providers are involved. We encourage our members to keep their PCP informed of any change in their medical condition including visits to an intermediate, skilled or rehab facility; an inpatient or outpatient center; an emergency room or urgent care setting; a VA clinic, health fair, mental health care provider or specialists as well as any tests, medications or treatments that were recommended. We also strongly encourage the PCP to ask the member about these and to clearly communicate with any specialist.

For improved continuity and coordination of care, we suggest the following:

- Mail or fax updates as needed and include the information in the patient's medical record
- Schedule a phone consultation or conference call when multiple doctors are involved in the member's care
- Provide concise documentation in the medical record to show that PCP/specialist consultation has occurred
- For our behavioral health members, our behavioral health providers are encouraged to discuss with their patients the importance of sharing their behavioral health care issues with their PCP.

*Coordinated care ensures optimal patient safety.*

As a contracted provider with The Health Plan you must always submit a claim for payment of services to The Health Plan prior to billing our members, even if you have received a pre-service determination denial 🍏

## CMS Taxonomy Update

### Proper Codes Reduce Claim Rejection

To aid in providing quality and consistent patient care, The Health Plan's Pharmacy Benefit



Manager, Express Scripts, would like to remind our prescribers to assure that proper taxonomy codes have been selected on the NPPES website. Accurate taxonomy codes help to reduce potential claim rejections, at

the point of service, related to prescriber criteria which must be met as determined by federal and state laws. For assistance with updating a taxonomy code click here for a list of FAQs:

[https://gallery.mailchimp.com/acf34afeea6c3a5d0f0853d03/files/1afbc05d-367f-423f-9b3c-0610c1a63b36/Taxonomy\\_Logic\\_FAQ.pdf](https://gallery.mailchimp.com/acf34afeea6c3a5d0f0853d03/files/1afbc05d-367f-423f-9b3c-0610c1a63b36/Taxonomy_Logic_FAQ.pdf) 🍏



## Double-Checking Readings

# Blood Pressure Readings

The first in office blood pressure (B/P) can sometimes be misleadingly high. Patients may have rushed into the office due to trying to find a parking space, be worried about their health or test results, or an ill-fitting B/P cuff may have been used. B/P readings greater than 140/90 mmHg may result in starting on medication or increasing their current blood pressure regimen. If the initial blood pressure in your office is elevated, consider having office staff recheck the reading. Having the patient return to the office to have their blood pressure rechecked is a reimbursable cost using the CPT billing code 99211. 🍏

## West Virginia Medicaid

# Telehealth/Telemedicine Benefit Summary

West Virginia Medicaid covers and reimburses a limited number of telehealth services that are provided to eligible members by enrolled practitioners via a telecommunication system. West Virginia Medicaid utilizes the Centers for Medicare and Medicaid Services (CMS) guidance for Telehealth Services. The Health Plan follows CMS's guidelines.

Visit <https://dhhr.wv.gov/bms/Pages/Manuals.aspx> for the complete WV Medicaid Telehealth Policy. 🍏

# Pre-Authorization Changes

## Behavioral Health

Effective July 1, 2019 the following have been added to the Behavioral Health Pre-Authorization List:

### Inpatient Care Addition

- Residential Adult Services for Substance Use Disorder Waiver: ASAM Level 3.1 (H2036U1HF), ASAM Level 3.3 (H2036U3HF), ASAM Level 3.5 (H2036U5HF) and ASAM Level 3.7 (H2036U7HF)

### Ambulatory Services Addition

- Peer Recovery Support (H0038)

Click here to view the full Behavioral Health Pre-authorization Requirements List: [myplan.healthplan.org/Provider](https://myplan.healthplan.org/Provider) 🍏

## Clinical Practice Guidelines Available Online

The Health Plan and participating practitioners review and update the preventive health guidelines and clinical practice guidelines, which are available to you as a reference tool to encourage and assist in planning your patients' care. To help make the information more accessible and convenient for you, we post the complete set of guidelines online. Just visit [healthplan.org/providers/patient-care-programs/quality-measures](https://healthplan.org/providers/patient-care-programs/quality-measures) to view standards, guidelines and program descriptions for Quality Improvement, Disease Management and Behavioral Health practice guidelines. 🍏

## REMINDER: Signatures, Credentials and Dates Are Important

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



## REMINDER: Hours of Operation

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



# Billing Medicare Advantage

## Non-covered Medical Services

Part of your responsibility as a contracted provider is to inform your patients when a service is not covered (or statutorily excluded) by The Health Plan. In order for The Health Plan 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 below. 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 The Health Plan.

### **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 Evidence of Coverage (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 in field #23 of the CMS1500 form.

When claims are billed with these modifiers, they are processed with the appropriate codes for member financial liability and you may bill the member.

However, if you bill The Health Plan for non-covered services without using the GA or GY modifier, The Health Plan will deny your claim as provider responsibility. If you bill us for covered services with the GY or GA modifier, The Health Plan will deny your claim for incorrect use of modifier. 🟢

## QIO Update

The Quality Improvement Organization for serving Medicare beneficiaries in West Virginia and Ohio has changed from KEPRO to Livanta BFCC-QIO Program, effective June 8, 2019.

Livanta BFCC-QIO Program has a group of doctors and other health care professionals who are paid by the Federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. Livanta BFCC-QIO Program is an independent organization. It is not connected with our plan.

You should contact Livanta BFCC-QIO Program in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

### **West Virginia Beneficiaries Contact:**

Livanta BFCC-QIO Program  
Call: 1.888.396.4646, TTY 1.888.985.2660.  
Write: Livanta BFCC-QIO Program  
10820 Guilford Road, Suite 202  
Annapolis Junction, MD 20701  
Website: [livantaqio.com/](http://livantaqio.com/)

### **Ohio Beneficiaries Contact:**

Livanta BFCC\_QIO Program  
Call: 1.888.524.9900, TTY 1.888.985.8775.  
Write Livanta BFCC-QIO Program  
10820 Guilford Road, Suite 202  
Annapolis Junction, MD 20701  
Website: [livantaqio.com/](http://livantaqio.com/) 🟢