WEST VIRGINIA
Department of
Health & **Human** Resources
BUREAU FOR
MEDICAL SERVICES

West Virginia Medicaid Provider Newsletter

350 Capitol Street, Room 251, Charleston, WV 25301　　　　**Qtr. 3, 2015**

Managed Care Changes for State Fiscal Year 2016

As of July 1, 2015, Medicaid members who are currently enrolled with a managed care organization (MCO) began receiving behavioral health services through their MCO. Representatives from the West Virginia Department of Health and Human Resources (DHHR), the Bureau for Medical Services (BMS), the MCOs and behavioral health providers have been meeting for several months to ensure a smooth transition for Medicaid members.

The MCOs will allow members to continue seeing out-of-network providers for up to 90 days and will honor all pre-established prior authorizations. This will give members time to change to a provider which is enrolled with their current MCO. MAXIMUS, the new managed care enrollment broker, can assist members who wish to transfer to a new MCO which has the member's existing provider in-network.

Behavioral health providers serving Medicaid members in a MCO must start billing the MCO for all services provided on July 1 and thereafter. If a Medicaid member is not in a MCO, providers will continue to bill Medicaid through Molina Medicaid Solutions. If a provider has a question of whether a Medicaid member is in a MCO and/or what MCO they are a member of, they can:

- Ask the member to see their MCO card;

- Go to the provider portal at www.wvmmis.org and look up the member's eligibility (if they are a member of a MCO it will appear as his/her primary care provider (PCP)); or

- Call Molina Provider Services at 888-483-0793.

Billing questions should be directed to the individual MCO.

BMS will also transition the Medicaid expansion population, approximately 164,000 individuals, into managed care under the SFY 2016 contract. Expansion members began receiving enrollment packets from MAXIMUS during the week of July 13. Members will have 30-45 days to decide which MCO they want to join. If they do not select a MCO by late August, a MCO will be chosen for them based on equitable distribution of the population to the plans. All questions regarding this process should be directed to MAXIMUS, the Managed Care Enrollment Broker, at 1-800-449-8466.

2015 Fall Provider Workshops

Watch your mail for registration materials for the 2015 Fall Provider Workshops:

Monday, October 19: Beckley-Tamarack

Tuesday, October 20: Huntington-Big Sandy Arena

Wednesday, October 21: South Charleston-Holiday Inn and Suites

Monday, October 26: Martinsburg-Holiday Inn

Tuesday, October 27: Wheeling-Olgebay Resort

Wednesday, October 28: Morgantown-Lakeview Resort

Thursday, October 29: Flatwoods-Days Inn

ICD-10 Live on October 1, 2015

WV Medicaid reminds providers that ICD-10 information and links to resources are available on the Molina website at https://www.wvmmis.com/SitePages/ICD-10%20Transition.aspx. The Centers for Medicare & Medicaid Services (CMS) website has a variety of tools such as a quick start guide, educational videos and tools for small and large provider offices at http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html.

Providers can also find ICD-10 Highlights on the Bureau for Medical Services website at http://www.dhhr.wv.gov/bms/Provider/ICD10/Pages/default.aspx. There are currently two presentations available, *"Countdown to ICD-10: Top 10 Things to Do to Prepare for ICD-10"* and *"Roles and Responsibilities: Training Spotlight on Physicians and Other Providers."* Future presentations are targeted for August and September.

WV Medicaid invites all providers to participate in external pilot testing of ICD-10 in preparation for the transition on October 1. External pilot testing will continue until August 28, 2015. To get started, review the *"WV ICD-10 Pilot Trading Partner Testing Manual"* on the Molina provider portal at https://wvmmis.com.

Important Reminder: Provider Revalidation Deadlines

WV Medicaid's revalidation of all providers enrolled prior to June 2013 must be completed by the end of 2015. Important deadlines for all providers are listed below:

July 2015 - Providers in Revalidation Phases 1 through 10 who have submitted an incomplete application
Beginning in July 2015, a list of providers who have submitted an incomplete application will be posted on the BMS website. The list will be refreshed every 2 weeks through September 30, 2015.

July 2015 - Providers in Revalidation Phases 5 through 10 who have not submitted an application
In July 2015, a list of all providers in Phases 5 through 10 who have not submitted an application will be posted on the BMS website for two weeks, then the providers will be placed on pay hold for 60 days. Once the 60 day period ends, the providers in Phases 5 through 10 who have not submitted an application to Molina will have their WV Medicaid participation terminated.

October 1, 2015 - All providers in Revalidation Phases 1 through 11
Providers in Phases 1 through 11 who have not submitted a complete application to Molina by October 1, 2015, will be placed on pay hold. Providers will have until December 1, 2015, to submit a complete application.

December 1, 2015 - All providers in Revalidation Phases 1 through 11
Molina will begin terminating the participation of all providers in Phases 1 through 11 who have not submitted a complete application. These terminations will be carried out through the month of December and completed by December 30, 2015.

If you have any questions or concerns regarding your enrollment or revalidation status, please contact the Molina Provider Enrollment Department at 304-348-3360 or 1-888-483-0793.

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CMS Makes Retroactive NCCI Edit Change

On October 1, 2014, the Centers for Medicare & Medicaid Services (CMS) implemented National Correct Coding Initiative (NCCI) edits for specific psychotherapy procedure codes. Recently, CMS released a retroactive update to these edits.

The October 2014 NCCI procedure-to-procedure (PTP) edits for practitioner services included code pairs for procedure code 90847 as a column 1 code and procedure codes 90832, 90833, 90834, 90836, 90837 and 90838 as the related column 2 codes. As a result of comments received regarding these edits, CMS will allow providers to append an appropriate PTP-associated modifier to one of the procedure codes if the services were provided in different sessions on the same date of service. This change will be effective for claims with dates of service on or after October 1, 2014.

For claims that are submitted with an individual psychotherapy procedure code and a family psychotherapy procedure code, providers may append modifier 59 to one of the psychotherapy procedure codes to indicate that a procedure or service was distinct or independent from other non-evaluation and management (E/M) services performed on the same day. Documentation that supports the provision of distinct or independent non-E/M services must be maintained in the member's medical record and made available to West Virginia Medicaid upon request.

As of June 10, 2015, the NCCI edits for psychotherapy procedure codes 90832, 90833, 90834, 90836, 90837, 90838 and 90847 were updated in Molina's claim processing system to allow the appropriate modifier. Claims processed before June 10, 2015, which were originally billed with the appropriate modifier, will be reprocessed. All other claims processed before June 10, 2015, may be replaced to include the appropriate modifier as described above.

For more information, contact Molina's Provider Relations Unit at 304-348-3360 or 1-888-483-0793.

WVCHIP Moves to Department of Health and Human Resources

The administrative oversight of the West Virginia Children's Health Insurance Program (WVCHIP) was moved from the Department of Administration to the Department of Health and Human Resources (DHHR) on July 1, 2015. The move was a result of legislation passed during the 2015 Legislative session.

In early 2016, WVCHIP will transition all medical and dental claims processing functions to Molina Medicaid Solutions. Providers will be required to enroll with WVCHIP using the current Medicaid Provider Enrollment and Application processes. Providers are strongly encouraged to begin the enrollment process as soon as possible by completing the survey at https://www.surveymonkey.com/s/WVCHIPParticipationSurvey. Failure to enroll by or before January 2016 may cause delay in payment or disruption of services for WVCHIP members. More information regarding this transition is available at www.chip.wv.gov and www.wvmmis.com.

Licensed Independent Clinical Social Workers

Starting in July 2015, West Virginia began enrolling Licensed Independent Clinical Social Workers as Medicaid providers. Interested practitioners should contact Molina's Provider Enrollment Unit at 304-348-3360 or 1-888-483-0793 for an application.

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Qualitative Data Test Pilot is Ready to Improve Quality of Care

The Bureau for Medical Services (BMS) Quality Unit is ready to improve the quality of care for Medicaid members with the start of its new qualitative data test pilot projects. On December 21, 2012, the Centers for Medicare & Medicaid Services (CMS) launched the Adult Medicaid Quality Grant Program: Measuring and Improving the Quality of Care in Medicaid. The grant project was created to support state Medicaid agencies in developing a team to collect report and analyze data on the Core Set of Health Care Quality Measures for Adults enrolled in Medicaid. The three main goals for the grant are:

- Testing and evaluating methods for collection and reporting of the Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid in various delivery care settings;

- Developing staff capacity to report the data, analyze and use the data for monitoring and improving access and quality of care in Medicaid; and

- Conducting at least two Medicaid quality improvement projects related to Initial Core Set Measures.

CMS chose 26 states to participate in the grant program including West Virginia. States that were selected for the program received a grant of up to $2 million. West Virginia launched two quality improvement projects. The first targets postpartum care rates. The West Virginia state average indicates 62.7% of Medicaid members were not attending their follow-up visits within the required time frame. The Quality Unit recruited Thomas Memorial Hospital in South Charleston, Cabell-Huntington Hospital in Huntington and Monongalia General Hospital in Morgantown as the test pilot sites for this project. Also included in the project are three Medicaid Managed Care Organizations: Unicare Health Plan of WV, Coventry Cares of WV and The Health Plan. The chosen sites will work with members to keep follow-up doctor appointments; screen for depression and promote birth control.

The second project, Follow-up after Hospitalization for Mental Illness will focus on members from ages 21 to 64 who are hospitalized for specific mental illness diagnoses. Thomas Memorial Hospital, Fairmont General Hospital, Princeton Community Hospital and St. Mary's Hospital in Huntington have been identified as test sites for this project. The chosen sites will work with patients so they do not miss their doctor appointments.

The WV Medicaid Quality Unit hopes the test sites will show improvement in follow-up care. Their goal is to increase the State average for follow-up visits by 5% statewide by 2016. The Adult Medicaid Quality Medicaid Grant Program is a part of a cost-savings initiative whose goal is to improve the quality of care for Medicaid members.

Meet the Medicaid Pharmacy Unit

The Pharmacy Unit is responsible for creating policies, overseeing point of sale claims as well as maintaining the criteria for the Preferred Drug List (PDL) and drugs that fall under the Prior Authorization category. Medicaid Expansion has had a great impact on the Unit's workload. Since the expansion, daily claims processed have increased by 75%. In 2014, WV Medicaid reimbursed over six and a half million prescription claims that totaled over $377.6 million, and the total is predicted to grow as new and old drugs become more expensive. The Unit's team of five work diligently to maintain their myriad of day-to-day responsibilities while working with the Pharmaceutical and Therapeutics (P&T) Committee and the Drug Utilization Review (DUR) Board to make decisions on the PDL as well as the criteria for Prior Authorization drugs.

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Meet the Medicaid Pharmacy Unit (continued)

Vicki Cunningham, R.Ph, Director of the Bureau for Medical Services (BMS) Pharmacy Unit, uses her expertise as a pharmacist to guide the daily functions of the unit while ensuring Medicaid members receive the most therapeutically appropriate and cost-effective drugs they require to maintain their health.

The P&T Committee makes recommendations regarding the status of drugs (preferred and non-preferred) on the PDL. The Pharmacy Unit works with the members of the Committee to develop meeting agendas, clinical recommendations, monographs and financial recommendations on the selection of drugs for the PDL. The Committee must be careful when reviewing their decisions as they will have an immense effect on both members and providers.

"We create a PDL and prior authorization for drugs that include therapeutic categories that are non-preferred. The categories on the PDL encompass about 90% of the medications prescribed for Medicaid members. The decisions we make about the PDL influence prescribing habits," said Cunningham.

Sitting: Brian Thompson, Vicki Cunningham
Standing left to right: Bill Hopkins, Anita Souder and Doug Sorvig

The DUR Coordinator Brian Thompson works with the Board to develop the agenda for the DUR Board meetings, prepares clinical information for the members to review and assists the Board chairman during quarterly meetings. The Unit works with the Retrospective DUR vendor responsible for giving providers educational interventions for the Board to review and reports on retrospective drug utilization for the Board.

The Unit also tackles the issue of increased costs of both old and new generic drugs along with new and more expensive drugs. Breakthrough drugs such as Sovaldi, Harvoni and Viekira Pak cost around $84,000 for a 12-week treatment regimen for Hepatitis C. Arthritis and psoriasis drugs are high in demand and have seen an increase in treatment cost as well. The challenges that the Pharmacy Unit handles requires Cunningham and her team to be vigilant in their reviews when considering which drugs to add to the PDL.

"We review all new drugs carefully, expand our PDL whenever possible, and work hard to be helpful to members and providers when they call," said Cunningham.

The Pharmacy team includes Pharmacy Services Director Vicki Cunningham, DUR Coordinator Brian Thompson, MS, Phar.D.; William B. Hopkins, Pharmacy Operations Manager; Doug Sorvig, Health and Human Resource Specialist Senior; and Anita Souder, Health and Human Resource Associate.

The Pharmacy Unit is looking forward to sustaining a therapeutically effective and cost-efficient Preferred Drug List, containing costs appropriately and implementing a medication management program for members in long-term therapy. Cunningham understands that her Unit will continue to face those challenges as they deal with the rising cost of drugs, but she is confident her team will maintain those goals. Contact the Pharmacy Unit at 304-356-4537.

Contact Us! Phone: 304-558-1700 Email: DHHRBMSupport@wv.gov Online: www.dhhr.wv.gov/bms/

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New Drug Screening Guidelines

On January 1, 2015, the Centers for Medicare and Medicaid Services issued new coding guidelines for reporting drug testing procedures and changes to current code policies in an effort to promote best practice standards and collaborative health care. The new (HCPCS) codes G6030 – G6057 are covered services for specific drugs and drug classes. The requirements for the new codes include:

- A laboratory certification – toxicology;
- Establishment of an initial benefit per member per code, 30 screens per rolling year;
- Prior authorization required if benefit exceeds limit;
- Not to be utilized if G0431 and G0434 can be appropriately used to screen for multiple drug classes;
- Not to be used only for monitoring substance abuse treatment interventions; and
- HF modifier is to be billed when the ordering, prescribing, referring (ORP) indicates the screening is related to substance abuse treatment.

Prior Authorization must be obtained through the Utilization Management Contractor, APS Healthcare. While code G6058 will require toxicology laboratory certification as the other codes, it is not to be used for substance abuse treatment and monitoring substance abuse treatment interventions; and does not require prior authorization but is subject to retrospective record review.

Policy changes to current drug screening codes G0431 and G0434 require new procedures to receive payment related to substance abuse treatment services. For example, drugs such as Suboxone will fall under the new procedure guideline. Changes to both codes are:

- Establishment of an initial benefit limit per member per code (30 screens per member without prior authorization);
- Prior Authorization required to exceed the benefit limits;
- Inclusion of the HF modifier on all claims for these codes when related to substance abuse treatment ;and
- Confirmation testing will not be reimbursed related to substance abuse treatment.

For questions regarding these new procedures and guidelines, contact APS Healthcare at 1-800-346-8272.

APS Update: WV Medicaid Health Homes Program

On July 1, the West Virginia Medicaid Health Homes Program celebrated its first birthday. The eight Health Home providers have reached out to approximately 1,200 Medicaid members receiving services in Cabell, Kanawha, Mercer, Putnam, Raleigh and Wayne counties diagnosed with Bipolar Disorder, with or at risk of Hepatitis B or C.

The Bureau wants to remind all providers that they can assist in the success of this program by:

- Assisting in the care coordination for members; or
- Referring eligible members who may not be aware of this program.

Members of the treatment team will be notified of their patient's condition, facilitating care coordination across medical disciplines. The goal of the Health Homes program is to make the provider aware of relevant changes in a member's condition and to reduce inpatient hospitalization. Although the current program is only in six counties, the state is planning to expand the current program to other counties and other eligible conditions.

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APS Update: WV Medicaid Health Homes Program (continued)

To learn more about the WV Medicaid Health Home Program or to refer a patient, please visit the BMS website at http://www.dhhr.wv.gov/bms/ or contact Richard Ernest at 304-558-1700.

Coding Corner

All surgical procedures include the pre-, intra-, and post-operative work required as part of the procedure. A separate evaluation and management (E&M) service cannot be billed for this work. Billing an E&M service separately for this work is considered procedure code unbundling.

Work that is separate and significantly identifiable from the work included in the surgical procedure may be billed separately. However, the appropriate CPT modifier must be appended to the procedure code(s).

When an E&M service is for the purpose of deciding whether to perform the surgery, the E&M service with the appropriate CPT modifier appended may be billed on the day of or day before a major surgical procedure. A major surgical procedure is defined as a procedure with a 90-day global period. Any other E&M services included in the surgical package are not separately reportable.

Follow-up services, including complications arising from the procedure, falling within the global period of a surgical procedure are not separately reportable. If an unrelated E&M service is performed during the global period of a prior surgical procedure, the appropriate CPT modifier must be appended to the E&M procedure code(s).

BMS Expanding Presumptive Eligibility Determination

In order to reach as many individuals as possible who may be eligible for Medicaid, the Bureau for Medical Services (BMS) in August 2015 will expand the entities which may determine presumptive eligibility for Medicaid. In addition to hospitals, federally qualified health centers, rural health clinics, comprehensive community behavioral health centers, and free clinics will have the option to determine presumptive Medicaid eligibility for their patients.

Medicaid presumptive eligibility may only be made for people who fall under one of these categories:

- Children
- Pregnant women
- Adults between the ages of 19 and 64
- Former West Virginia foster children up to age 26
- Women who may gain eligibility through the breast and cervical cancer screen program according to state and federal requirements

Applicants are allowed only one presumptive eligibility determination per 12 month period, regardless of the type of entity which makes the determination, or if pregnant, per pregnancy. Entities will use the WV inROADS online application system to make presumptive determination decisions.

In order to determine presumptive eligibility an entity must be a federally qualified health center, rural health clinic, comprehensive community behavioral health center, free clinic or a hospital and must be a Medicaid approved provider. Entities interested in becoming an approved presumptive eligibility provider must submit an enrollment package to the BMS. In addition, any employees, volunteers, or third party vendors making presumptive eligibility determinations must complete an online training course. More information on the Medicaid Presumptive Eligibility Program can be found at http://www.dhhr.wv.gov/bms/Pages/default.aspx.

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Fingerprint-Based Criminal Background Checks Guidance Issued

On June 1, 2015, the Centers for Medicare and Medicaid Services (CMS) issued guidance to State Medicaid Directors on the implementation of fingerprint-based criminal background checks (FCBC). This guidance was issued as directed by Section 6401(a) of the Affordable Care Act and 42 CFR Part 455 subpart E.

Under 42 CFR 455.450, a state Medicaid agency is required to screen all provider applications, including initial applications, applications for a new practice location, and applications for re-enrollment or revalidation, based on categorical risk level of "limited," "moderate," or "high." The risk levels relate to those providers and provider categories which pose an increased financial risk of fraud, waste or abuse to the Medicaid program. When a Medicaid agency designates that a provider's categorical risk level is "high," the agency must require criminal background checks including fingerprinting. The requirement to submit fingerprints applies to both the "high" risk provider and any person with a 5 percent or more direct or indirect ownership interest in the provider.

States have 60 days from June 1, 2015 (September 1, 2015), to begin implementation of the FCBC requirement and must complete implementation by June 1, 2016. Implementation means that the state Medicaid agency has conducted an FCBC with respect to each provider that the agency has designated as "high" risk. Those providers who are also enrolled as Medicare providers or who are providers in another state's Medicaid or CHIP program and who are considered "high" risk and have already had a FCBC do not have to undergo another check.

The West Virginia Bureau for Medical Services has followed the recommended CMS guidelines for determining the risk level of provider types:

- Limited – Physicians or non-physician practitioners, with the exception of physical therapists (PTs), and group practices, except PT groups; ambulatory surgical centers; end-stage renal disease facilities; federally qualified health centers; hospitals; Veterans Administration and federally-owned hospitals; Indian health programs; mammography screening centers; mass immunization billers; organ procurement organizations; newly enrolling pharmacies; radiation therapy centers; religious non-medical health care institutions; and skilled nursing facilities.

- Moderate – Community mental health centers; comprehensive outpatient rehabilitation facilities; Hospice organizations; independent diagnostic testing facilities; independent clinical laboratories; nonpublic, non-government owned or affiliated ambulance service suppliers; currently enrolled home health agencies; durable medical equipment, prosthetics, orthotics (DMEPOS) suppliers; and individual and group PTs.

- High – Home health agencies and suppliers of DMEPOS.

A state Medicaid agency must terminate or deny enrollment of a provider if the provider or any person with a 5% or greater direct or indirect ownership interest, who is required to submit fingerprints does one of the following:

- Fails to submit them within 30 days of the Medicaid agency's request;
- Fails to submit them in the form and manner requested by the Medicaid agency; or
- Has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid or CHIP program in the last 10 years.

The Agency may allow the provider to enroll if termination or denial of enrollment is determined not to be in the best interest of the Medicaid program and documents that justification in writing.

Providers who must meet the FCBC requirement will receive notification from BMS informing them of the procedures they must follow. To view a copy of this federal guidance, please visit the CMS website at http://www.medicaid.gov.

Contact Us! Phone: 304-558-1700 Email: DHHRBMSupport@wv.gov Online: www.dhhr.wv.gov/bms/

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BMS Website Gets New Look

The Bureau for Medical Services has a new website. The website was created to make it easier for providers, members, stakeholders and the public to find information.

On the welcome page, www.dhhr.wv.gov/bms, topic areas include About Us, Medicaid Expansion, WV Health Homes, CMS, Publications, Public Notices, and Contact Us. The CMS tab includes the WV Medicaid State Plan, State Plan Amendments, informational bulletins, health plan advisories and guidance, formal responses by CMS regarding state plan amendments and waiver approvals.

Another important difference to note is the Public Notices tab, which includes all items available for public comment. On the former site, this information was placed under News and Announcements. Publications is a new addition to the website and includes all BMS newsletters, annual reports, brochures, etc.

The updated News and Announcements section will have press releases and general information about the Medicaid program.

At the bottom of the welcome page are three navigation panes: Providers, Members, and Home and Community Based Programs. The Provider information pane includes the Policy Manual, fee schedules, pharmacy information, HCPCS/Drug Codes and more. The Members pane includes information which is primarily for Medicaid members or perspective members. There is some information which may be of interest to providers, such as co-payment and managed care information. The Home and Community Based Programs pane includes information regarding the Medicaid Waiver programs, behavioral health services, nursing services, etc. This section is for both members and providers involved in receiving or providing services in the community.

Those who subscribed to the RSS News Feed on the former BMS website will need to re-subscribe under Public Notices or News and Announcements.

Questions or comments regarding the new website can be submitted via email using the Contact Us tab at the top of the Welcome page.

WV Participates in New MMIS Enterprise Certification Process

West Virginia is one of the first states to participate in the new Medicaid Management Information System (MMIS) Enterprise Certification process which is a phased evaluation against critical successes. On June 16 and 17, 2015, the Bureau for Medical Services, the Office of Management Information Services, Molina and BerryDunn staff participated in a Final Detailed Design Gate Review with representatives from the Centers for Medicare and Medicaid Services.

Take Me Home, West Virginia Program Update

The Bureau for Medical Services (BMS) Take Me Home, West Virginia program has a new Transition Navigator partner agency, the Coordinating Council for Independent Living (CCIL). CCIL began providing Transition Navigator services statewide in early July.

Between the Area Agencies on Aging (AAA) and CCIL Take Me Home, West Virginia now has approximately 11 Full-Time Equivalent (FTE) Transition Navigators across the state supporting eligible Medicaid members to transition from facility-based long-term services and supports to their own homes and apartments in the community.

For more information, please visit the Take Me Home, West Virginia program website at /www.dhhr.wv.gov/bms/Programs/Takemehome or call 304-356-4926.

Physician Assistant Enrollment Required

Historically, Physician Assistants (PAs) have been considered "hidden" providers in West Virginia's Medicaid program because they are able to bill under a physician. This practice results in accurate tracking or member and provider data, and possibly fraud, waste and abuse as it prevents patients, regulators, employers and legislators from identifying who is accountable for a patient's care. Moreover, policymakers were receiving inaccurate data which lead to uneconomical allocation of taxpayers' funds. Once these inadequacies were acknowledged, it became a priority that a requirement must be established in order to improve patient care and prevent fraud, waste and abuse.

The Affordable Care Act of 2010 established a requirement that all providers of service for Medicaid members must be enrolled. In addition, claim edits are required to ensure that all ordering, referring and prescribing providers are enrolled before payment can be made. The enrollment of PAs in West Virginia Medicaid along with the federally required provider screening and enrollment process is expected to result in the proper identification of PAs for provider affiliation, claims payment and publication in provider directories. It also makes the process of finding care options easier for members, especially in underserved areas.

Providers that employ PAs who have not been enrolled must fulfill the BMS deadline of December 31, 2015, for payment of PA services. Those who do not enroll PAs by the deadline could face costly consequences such as denial of payment from West Virginia Medicaid. For questions regarding enrollment for PAs, please contact Molina Medicaid Solutions at 888-483-0793 or 304-348-3365.

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The *West Virginia Medicaid Provider Newsletter* is a joint quarterly publication of the West Virginia Department of Health and Human Resources (WV DHHR), Bureau for Medical Services (BMS) and Molina Medicaid Solutions.

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888-483-0793
304-348-3360
wvmmis@molinahealthcare.com (email)

EDI help desk
888-483-0793, prompt 6
304-348-3360

Provider Enrollment
888-483-0793, prompt 4
304-348-3365

Molina PR Pharmacy help desk
888-483-0801
304-348-3360

Member Services
888-483-0797
304-348-3365
Monday-Friday, 8:00 a.m. to 5:00 p.m.

Molina Provider Fax
304-348-3380

Claim Form Mailing Addresses:
Please mail your claims to the appropriate Post Office Box as indicated below. PO Boxes are at Charleston, WV 25337.

PO Box 3765 NCPDF UCP Pharmacy

PO Box 3766   UB-92

PO Box 3767 CMS-1500

PO Box 3766 ADA-2002

Hysterectomy, Sterilization and Pregnancy Termination Forms
PO Box 2254
Charleston, WV 25328-2254

Provider Enrollment & EDI Help Desk
PO Box 625
Charleston, WV 25337-0625
FAX: 304-348-3380

Molina Mailing Addresses:

Provider Relations & Member Services
PO Box 2002
Charleston, WV 25327-002
FAX: 304-348-3380

Provider Enrollment & EDI Help Desk
PO Box 625
Charleston, WV 25337-0625
FAX: 304-348-3380

MCO Contacts:

Coventry Health Care of WV
888-348-2922

The Health Plan
888-613-8385

Unicare
800-782-0095

WV Family Health
855-412-8002

Vendor Contacts:
APS Healthcare
304-343-9663

MAXIMUS
800-449-8466

WVMI
800-542-8686

> **Please send provider enrollment applications and provider enrollment changes to:**
>
> **Molina Medicaid Solutions PO Box 625, Charleston, WV 25337**

Molina Automated Voice Response System (AVRS) Prompt Tree

Please make sure that you are utilizing the appropriate prompts when making your selection(s) on the AVRS system to ensure that you will be connected to the appropriate department for your inquiry. Once you have entered in your provider number, the following prompts will be announced:

1.   Accounts Payable Information
2.   Eligibility Information
3.   Claim Status Information
4.   Provider Enrollment Department
5.   Hysterectomy Sterilization Review
6.   EDI Help Desk/Electronic Submission Inquiries
7.   LTC Department
8.   EHR Incentive
9.   BHHF

Claims and Application Information
To expedite timely claims processing, please make sure claims are sent to the correct mailing address as indicated below:
- Facilities and Institutional Providers who bill on a UB04 Claims form:
  PO Box 3766, Charleston, WV 25337
- Medical Professionals billing on a CMS Claims form:
  PO Box 3767, Charleston, WV 25337
- Dental Professionals billing on ADA 2006 Claims form:
  PO Box 3768, Charleston, WV 25337
- Pharmacy Claim form NCPDP UCF:
  PO Box 3765, Charleston, WV 25337

Suggestions for Web Portal Improvements
We are looking for ways to improve the Provider Web Portal. If you have any suggestions on how we can improve the portal to make it more user friendly, please contact our EDI helpdesk at:
edihelpdesk@molinahealthcare.com.

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