

Substance Use Disorder Waiver is Approved

West Virginia will soon have another tool in its arsenal to fight the substance abuse crisis: the Substance Use Disorder (SUD) Waiver. The Centers for Medicare and Medicaid Services (CMS) approved the West Virginia Department of Health and Human Resources (DHHR), Bureau for Medical Services (BMS) 1115 Demonstration Waiver application to expand substance use treatment and services to Medicaid members. The Waiver allows the state to help address the substance abuse crisis by ensuring Medicaid members get the right treatment at the right time.

“This waiver allows DHHR to more effectively prevent and treat substance abuse issues for Medicaid enrollees through expanded treatment services,” said Cindy Beane, BMS Commissioner. “This is another important tool in West Virginia’s fight against substance abuse under the leadership of Governor Jim Justice, who has championed this strategy.”

“The entire SUD Waiver team is relieved to hear of the approval. We are excited and eager to move forward towards implementation of these new, and necessary services,” said Jeff Lane, BMS SUD Waiver Program Manager.

The SUD Waiver will be implemented in two phases. The first phase, including coverage of methadone treatment and use of the Screening, Brief Intervention Referral to Treatment (SBIRT) assessment tool, begins January 1, 2018. Phase 2 will see full implementation of the Waiver and is scheduled for July 2018. This will allow payment for all levels of short-term residential treatment services, including intensive outpatient treatment, partial hospitalization and withdrawal management services; peer recovery support specialists; and the “Naloxone Initiative,” allowing reimbursement for the drug Naloxone, for its administration and for a “warm handoff” to a local SUD treatment provider for assessment and possible referral to residential treatment. The goal of the SUD Waiver is to allow BMS to more effectively prevent and treat substance use disorders for Medicaid enrollees through an expanded continuum of care.

Other features of the SUD Waiver include:

- SUD prevention and treatment strategies focused on adolescents.
- Building on existing efforts to raise awareness and address the prevalence of babies born with exposure to substance use.
- Expanding coverage of withdrawal management in regionally identified settings.
- Enhancing access to outpatient SUD treatment as appropriate when residential treatment is not required.
- Covering a set of clinical and peer recovery support services and recovery housing supports designed to promote and sustain long-term recovery.

Services will be available to all West Virginia Medicaid members:

- At-risk families will be eligible for services to allow for community-based treatment and supports to prevent children from being placed out of the home.
- Foster care youth will be able to receive SUD treatment services through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.

Substance Use Disorder Waiver is Approved (Cont.)

The Waiver allows West Virginia Medicaid to pay for SUD services that were not previously covered, including drug treatment such as methadone. “All levels of residential treatment, including withdrawal management, intensive outpatient, and partial hospitalization will be covered,” says Lane.

Now that the SUD Waiver has been approved and is ready to launch, West Virginia Medicaid will provide members with information about the new covered services. Managed Care Organizations (MCOs) will help promote services by providing information to their members as well. Lane is looking forward to the positive impact of the Waiver on the drug epidemic.

The SUD Waiver program is currently seeking multiple types of providers for the new waiver services. Once the program policy manual is complete and available for public comment, provider requirements will be announced. Providers interested in participating in the SUD Waiver program may contact Jeff Lane at 304-558-1700.

Covered Outpatient Drug Changes

On January 21, 2016, the Centers for Medicare & Medicaid Services (CMS) issued the Covered Outpatient Drugs final rule that addressed key areas of Medicaid drug reimbursement and changes to the Medicaid Drug Rebate Program under the Affordable Care Act. The rule was established to assist state Medicaid programs and the federal government in managing drug costs, establishing the long-term framework for implementation of the Medicaid drug rebate program, and creating a fairer reimbursement system for Medicaid programs and pharmacies. On August 23, 2017, BMS received approval for a state plan amendment (SPA 17-001) from CMS regarding the new payment methodology for outpatient drugs as mandated in the Covered Outpatient Drugs final rule. The effective date of this change was April 8, 2017.

The new methodology mandates state Medicaid programs are to reimburse for prescription outpatient drugs dispensed at a pharmacy with a professional dispensing fee and a structure designed to reimburse on the actual acquisition cost of drugs. The professional dispensing fee approved for West Virginia Medicaid is \$10.49 per prescription. Reimbursement for drugs is based on the lowest of the National Average Drug Acquisition Cost (NADAC), Wholesale Acquisition Cost (WAC) when NADAC is not available, Federal Upper Limit (FUL), State Maximum Allowable Cost (SMAC), submitted ingredient cost or the provider’s usual and customary charge. When drugs are billed at the usual and customary charge no dispensing fee is added. Drugs purchased through the 340B program must be billed at the actual acquisition cost (AAC), which shall not exceed the 340B ceiling price, and are eligible for the \$10.49 professional dispensing fee. Facilities purchasing drugs through the Federal Supply Schedule (FSS) will be reimbursed no more than their actual acquisition cost, plus the professional dispensing fee. Facilities purchasing drugs at nominal price (outside 340B or FSS) will be reimbursed by their actual acquisition cost plus the professional dispensing fee.

Specialty drugs not dispensed by a retail community pharmacy and dispensed primarily through the mail and drugs not dispensed by a retail community pharmacy (long-term care or institutional pharmacy when not included as part of an inpatient stay) will be reimbursed at the lowest of either the NADAC, WAC, SMAC, submitted ingredient cost or the provider’s usual and customary charge plus a professional dispensing fee. A one-time monthly dispensing fee per drug will apply to maintenance drugs dispensed in long-term care or other institutions.

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Physician administered drugs (those that have a Healthcare Common Procedure Code System (HCPCS) code or J Code) will be reimbursed at the Medicare reference price, 106% of the Average Sales Price (ASP) or in the absence of a fee on Medicare reference price, at WAC. Covered entities using drugs purchased under the 340B program for West Virginia Medicaid members can bill no more than their AAC. Dispensing fees may not be applied to these drugs. Instead the facilities supplying them receive administration fees since these drugs are administered in the facility (infusion centers or out-patient surgery units) or are physician administered to patients of the 340B covered entity.

Clotting factors from specialty pharmacies, hemophilia treatment centers and centers of excellence will be reimbursed at WAC plus the professional dispensing fee of \$10.49. Clotting factors were previously billed as HCPCS or J Codes but must now be billed as pharmacy claims.

Investigational drugs are not covered by West Virginia Medicaid.

Payment for compounded prescriptions will be based on the lower of NADAC or WAC. If NADAC is not available, FUL, SMAC submitted ingredient cost or usual and customary charges to the public including any sale price which may be in effect at the same time plus the dispensing fee. To qualify for payment, a compound must have at least one legend ingredient. A fee of \$6 will be added to the dispensing fee for extra compounding time required by the pharmacist. Neither the \$6 compounding fee nor the dispensing fee applies to the usual and customary reimbursement.

SPA 17-001 is posted on the BMS website and can be found at [http://www.dhhr.wv.gov/bms/CMS/SMP/Pages/Recent-State-Plan-Amendments-\(SPAs\).aspx](http://www.dhhr.wv.gov/bms/CMS/SMP/Pages/Recent-State-Plan-Amendments-(SPAs).aspx). Contact the BMS pharmacy division with questions at 304-558-1700.

Place of Service (POS) 19 Reminder

On January 1, 2016, a new Place of Service Code (POS) for Outpatient Hospitals was revised to differentiate between on-campus and off-campus provider-based hospital departments. As a result, the Centers for Medicare and Medicaid Services (CMS) added POS code 19 for “Off-Campus-Outpatient Hospital,” a portion of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and nonsurgical) and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

As a reminder, West Virginia Medicaid continues to accept POS 19 and should be used when billing services in the described setting. For additional information, please go to: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9231.pdf>

KEPRO Update

KEPRO has recently focused on educating providers and members on the Case Management and Organ Transplant processes for fee-for-service (FFS) members. If used properly, these processes can facilitate member participation and accountability as well as utilize cost effective measures while facilitating access to resources.

Medical Case Management is a collaborative process which includes member assessment, planning case coordination, advocating services which meet the needs of the member, monitoring, and evaluation to meet the members’ comprehensive healthcare needs. Many may play a role in the individual goals and outcomes that are developed with and for the member. Along with the member,

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KEPRO Update (Cont.)

these goals are discussed with healthcare providers, family members, guardians, legal representatives, and others.

Criteria for Case Management can be triggered by many things. Prior authorization of services in specific review areas results in an automatic referral of members to medical case management services. These referrals can be initiated by BMS, staff that are involved in the prior authorization process, hospitals, physicians, the member, and/or their legal guardian.

Case Management services must be necessary based on the member's diagnosis, treatment plan and any applicable criteria such as InterQual or BMS policy. There are many potential areas for Case Management, and some areas will be automatically assigned to Case Management such as organ transplant patients, private duty nursing services members, and members who have bariatric surgery.

All organ transplant requests are reviewed and managed by KEPRO. The organ transplant process was re-worked to ensure Medicaid members who require transplant services receive timely authorizations by working with providers to ensure a quick prior authorization process. The process for referring Medicaid members requiring organ transplants can be found at www.wvaso.kepro.com.

Managed Care Organization Provider Screening Reminder

All providers who would like to provide services to Medicaid members are federally required to enroll and revalidate with West Virginia Medicaid. If you have not completed enrollment and revalidation per the federal guidelines, your Managed Care Organization (MCO) contract will be terminated and you will no longer be eligible to provide services to Medicaid members.

For more information or to enroll, visit Molina's Provider Enrollment web page at www.wvmmis.com and click on the Provider Enrollment link.

Meet the BMS Director of Provider Services

Joy Dalton was hired as Director of Provider Services for the West Virginia Department of Health and Human Resources (DHHR), Bureau for Medical Services (BMS) in September. In her position, she oversees the BMS Quality Unit, provider enrollment, and West Virginia Medicaid Provider Manual coordination.

Dalton has an extensive background with West Virginia Medicaid, working for both DHHR's Management Information Services (MIS) and Molina Medicaid Solutions. With her experience, she understands there will be challenges with providers and already has plans to overcome them.

"There is a lot of Medicaid history. We are trying to make sure when we make decisions that if there were past issues, we do not repeat history. We engage a number of stakeholders to ensure that we make decisions based on all information at hand," says Dalton.



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Meet the BMS Director of Provider Services (Cont.)

Creation and approval of policies can be challenging for Dalton's team because they must envision the impact on providers and members. BMS program managers write policies and send them to the Policy Review Committee for consideration. Following approval, the policies are submitted to the West Virginia Medicaid leadership team for approval. Once they are approved, policies are posted for 30-day public comment and all comments are then considered before the policy is finalized.

"When making policies, we try to determine the impact on providers by reviewing the process and ensuring that we assess the changes to both the provider community and our members," says Dalton.

Dalton has many goals she wants to accomplish in her new position. She wants to update policies, invest significant energy into the enrollment process, and assist with revalidation and enrollment to make the process as concise and straight forward as possible. Dalton is looking forward to building working relationships with providers to allow them to deliver cohesive, excellent customer service to West Virginia Medicaid members.

Dalton is a native of Stone Gap, Virginia, with a Bachelor of Arts Degree from Marshall University and a Master's Degree in Business Administration from Strayer University.

Quality Corner: BMS Quality Unit Welcomes New Staff Program Coordinator

Amy Sutton has been chosen as Program Coordinator in the Quality Unit under Director DeeAnn Price. Sutton began her state tenure in 2008 at the West Virginia Department of Health and Human Resources (DHHR), Bureau for Children and Families (BCF) before joining DHHR's BMS in 2012 as a Data Analyst. Her new duties include reporting adult, child and Health Homes quality measures. In addition, she is responsible for identifying ways to improve Medicaid member's health outcomes and the State's quality rating. Sutton is very eager in taking on her duties because they play an important role for providers and West Virginia Medicaid members.

"Data is the driving force for a lot of Medicaid and Medicare initiatives. The data we gather about services Medicaid members are receiving and their conditions can help BMS establish new initiatives to assist members as well as providers," says Sutton.



She is also excited to be working on a team that can positively impact outcomes for some of the State's residents with high financial needs. Sutton is a Charleston, West Virginia, native who graduated from West Virginia State University with a Regents Bachelor of Arts Degree with an emphasis in Natural Sciences.

Coding Corner: MUE and Units

A MUE (Medically Unlikely Edit) is a unit of service (UOS) edit for a Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) code for services rendered by a single provider/supplier to a single beneficiary on the same date of service. The ideal MUE is the maximum UOS that would be reported for a HCPCS/CPT code on the vast majority of appropriately reported claims. MUEs are adjudicated either as claim line edits or date of service edits. The MUE program provides a method to report medically reasonable and necessary UOS in excess of an MUE for MUEs that are adjudicated as claim line edits.

When adding a claim line that has an MUE of one and it is done bilateral, you should only append modifier 50. If the provider bills the procedure on two separate lines with or without modifier RT/LT the MUE rule may apply. (There are some procedures that are an exception.)

Sometimes there are situations where it is medically reasonable and necessary to exceed the MUE limitation on a single date of service. In such situations, use CPT modifiers to report the same code on separate lines of a claim. CPT modifiers such as -76 (repeat procedure by same physician), -77 (repeat procedure by another physician; this would rarely if ever occur in Rad Onc and could be viewed as manipulation for payment), anatomic modifiers (e.g., RT, LT, F1, F2), and -59 (distinct procedural service) will accomplish this purpose. Modifier -59 should be utilized only if no other modifier describes the service. As always, documentation of clinical activities supporting the appropriate use of the modifiers should be maintained in the medical record.

Molina Staff at Fall Provider Workshops



Pictured from Left: Michelle Miller, Gloria Hayes, Katrena Edens, Debbie Rhodes, Tracy Beach and Misty Smith.

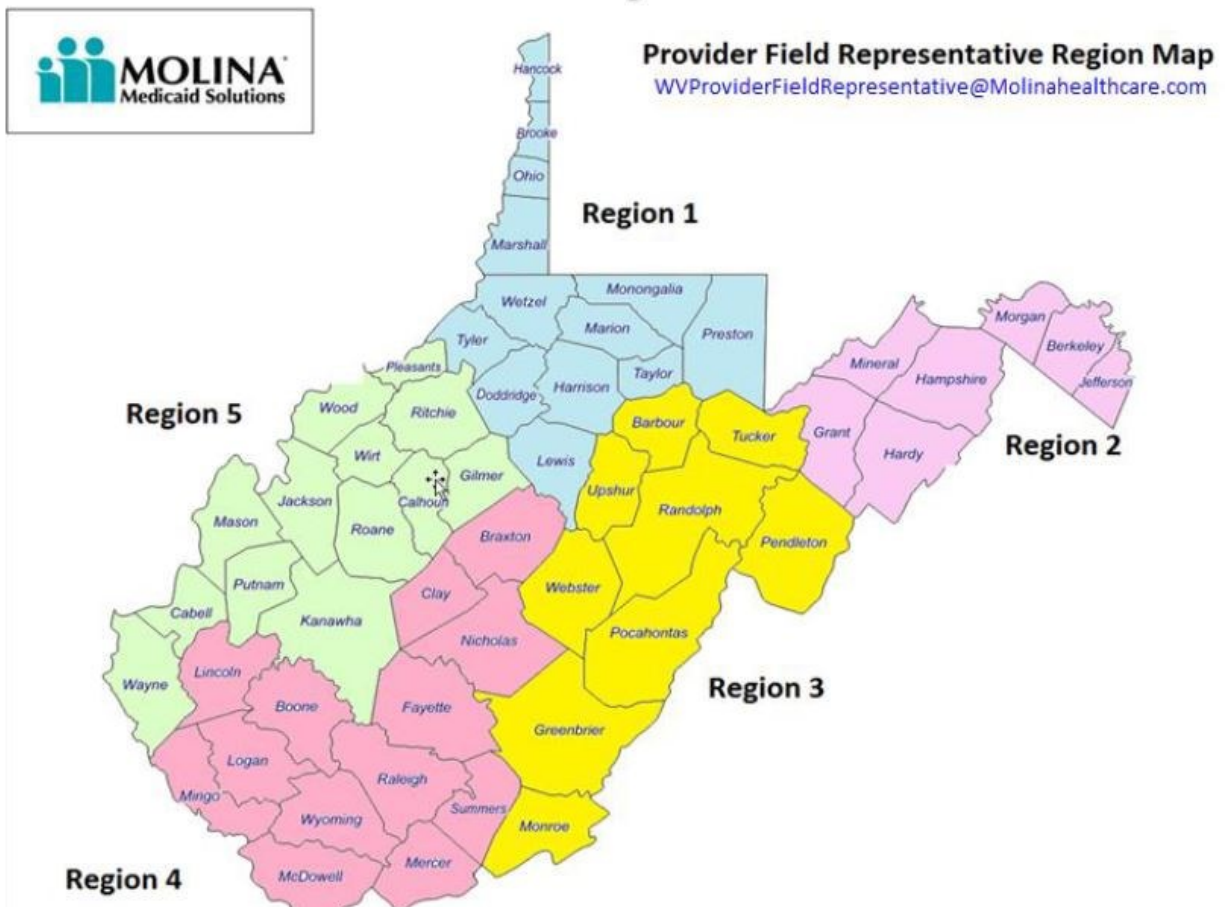
Molina Medicaid Solutions staff members Michelle Miller, Gloria Hayes, Katrena Edens, Debbie Rhodes, Tracy Beach and Misty Smith attended the Fall Provider Workshops held in eight cities around the state.

The group presented information to providers as well as addressed questions. Providers heard about upcoming developments that may impact them in the future from Molina, the Bureau for Medical Services (BMS), KEPRO (BMS Utilization Management Contractor), West Virginia Children's Health Insurance Program (WVCHIP), Maximus (BMS Managed Care Contractor) and the Managed Care Organizations (MCOs). The Provider Workshops are held a twice a year in the spring and fall.

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

Bill J. Crouch, DHHR Cabinet Secretary
Jeremiah Samples, DHHR Deputy Secretary
Cynthia E. Beane, DHHR BMS Commissioner

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Contact

Molina Medicaid Solutions

Provider Relations

888-483-0793

304-348-3360

wvmmis@molinahealthcare.com

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

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

Molina Claim Form Mailing Addresses

Please mail your claims to the appropriate Post Office Box as indicated below. PO Boxes

PO Box 3765 NCPDP UCF Pharmacy

PO Box 3766 UB-04

PO Box 3767 CMS-1500

PO Box 3766 ADA-2012

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

Aetna Better Health of WV
888-348-2922

The Health Plan

888-613-8385

Unicare

800-782-0095

WV Family Health

855-412-8002

Vendor Contacts:

KEPRO

304-3439663

MAXIMUS

800-449-8466

Please send provider enrollment applications and provider enrollment changes to:

**Molina Medicaid Solutions
PO Box 625
Charleston, WV 25337**

Claims Information

To expedite timely claims processing for Molina, please make sure claims are sent to the correct mailing address as indicated below:

- Facilities and Institutional Providers billing on a UB04 Claim form:
PO Box 3766, Charleston, WV 25337
- Medical Professionals billing on a CMS 1500 Claims form:
PO Box 3767, Charleston, WV 25337
- Dental Professionals billing on ADA 2012 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 suggestions on how we can make the portal more user friendly, please contact our EDI helpdesk, edihelpdesk@molinahealthcare.com.