

Molina Medicaid Solutions is now DXC Technology



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Bureau for Medical Services' Substance Use Disorder Waiver Launches Phase Two Services

West Virginia Medicaid members are now receiving additional Substance Use Disorder (SUD) Waiver services to further help with their road to recovery. The West Virginia Department of Health and Human Resources' (DHHR) Bureau for Medical Services (BMS) implemented Phase Two of the SUD Waiver services on July 1, 2018. Those services include:

- **Adult Residential Treatment:** West Virginia Medicaid now covers adult residential treatment levels adhering to the American Society of Addiction Medicine (ASAM[®]) criteria. These are comprehensive programs for adults ages 18 and older who have a diagnosis of substance abuse and/or co-occurring substance abuse/mental health disorder.
- **Peer Recovery Support Services:** Peer recovery support services are now covered by a trained and certified peer recovery specialist who has been successful in their own recovery process and can extend the reach of treatment beyond the clinical setting into a member's community and home environment.
- **Withdrawal Management Services:** West Virginia Medicaid now covers withdrawal management services. This licensed program provides short-term medical services on a 24-hour basis for stabilizing intoxicated members, managing their withdrawal and facilitating access to SUD treatment as needed by a comprehensive assessment.

"The entire SUD Waiver team is excited and eager to move forward towards implementation of these new and necessary services," said Jeff Lane, BMS SUD Waiver Program Manager.

Phase one services began in January 2018; those services included:

- **Screening, Brief Intervention, and Referral to Treatment (SBIRT):** Implemented statewide use of the widely-accepted SBIRT tool to identify SUD treatment needs among the Medicaid population.
Methadone treatment and administration: Added Medicaid coverage of methadone as a withdrawal management strategy, as well as the administration and monitoring of the medication, and related counseling services.
- **Naloxone Distribution Initiative:** Implemented a statewide initiative to make naloxone widely available and increase awareness of the benefits of naloxone in reversing the effects of an overdose.

The expansion of SUD Waiver services will allow the program to achieve its goals by providing the services to West Virginia Medicaid members that may impact the effects of the ongoing opioid epidemic, to help stop the flow of deaths resulting from overdoses, while offering appropriate

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Bureau for Medical Services' Substance Use Disorder Waiver Launches Phase Two Services (Cont.)

treatment for those who are addicted and suffering.

The expansion of SUD Waiver services will allow the program to achieve its goals by providing the services to West Virginia Medicaid members that may impact the effects of the ongoing opioid epidemic, to help stop the flow of deaths resulting from overdoses, while offering appropriate treatment for those who are addicted and suffering.

Lane is pleased with all of the services offered, especially the new Peer Recovery Support services.

“These new services offer our members their best opportunity yet to fight against addiction. Hopefully, they can get through detox then receive direct treatment for their substance use problems and progress towards aftercare in recovery. The new Peer Recovery Support services will give them the chance to talk with someone who has already experienced what they are going through, especially during the hard times that challenge their sobriety. There is now more support for them than before,” says Lane.

The SUD Waiver program is currently seeking multiple types of providers for the new waiver services. Providers interested in participating in the SUD Waiver program may contact Jeff Lane at 304-558-1700.

Providers Must Enroll to Prescribe for Medicaid Members

Prescribers for Medicaid enrollees must register with West Virginia Medicaid. Effective October 17, 2018, West Virginia Medicaid will deny all claims for prescriptions written by any prescriber not enrolled with West Virginia Medicaid. This includes hospital residents and interns, advanced practice nurse practitioners, physician assistants, and pharmacists who administer vaccines. Even though the facility you are employed by (clinic, hospital, or pharmacy) is currently enrolled, individual prescribers must also be enrolled. Failing to enroll with West Virginia Medicaid as a prescribing provider could cause serious consequences for your patients.

The requirement for prescribers to enroll is a provision of the Patient Protection and Affordable Care Act of 2010. All prescribers serving West Virginia Medicaid patients **MUST** enroll and their name and national provider identifier (NPI) must be recorded on claims for prescription medications submitted for Medicaid members on and after October 17, 2018. Providers may enroll as a billing provider or an “ordering, referring, or prescribing (ORP) provider.” “ORP only provider” is a category for prescribers who write orders, refer, or prescribe medications, but do not actually submit claims to Medicaid for their services. “ORP only providers” may not bill Medicaid for services.

If you are not already enrolled, you may go to the website of the West Virginia Medicaid claims processor, DXC Technology, at <https://www.wvmmis.com> and enroll online as a billing provider or as an “ORP only provider.” The quickest enrollment option is the ORP-only online application process, if applicable. Provider application approval is five days from receipt of a completed application and required documentation. All required documentation can be uploaded to the portal.

A paper application can be requested by calling DXC Provider Enrollment at 888-483-0793. To prevent interruptions in Medicaid members' access to needed prescription medications, prescribers must make sure they are enrolled with West Virginia Medicaid.

For questions, please contact DXC Provider Enrollment at 888-483-0793 or the DXC Pharmacy Help Desk at 888-483-0801.

Payment Error Rate Measurement (PERM) Update

The Centers for Medicare and Medicaid Services (CMS) implemented the Payment Error Rate Measurement (PERM) program to meet the requirements of the Improper Payments Information Act of 2002. Federal agencies are required to annually review and estimate the amount of improper payments identified for Medicaid and the State Children's Health Insurance Program (SCHIP). Under PERM, CMS conducts reviews in three areas of Medicaid and SCHIP programs: Fee-For-Service (FFS), Managed Care, and Program Eligibility. The results of these reviews will be used to produce both national and state-specific error rates. States are measured once every three years, and West Virginia Medicaid and SCHIP are included in review year 2020.

CMS has awarded contracts to a statistical contractor (who will calculate error rates), a documentation/database contractor (who will collect state-specific policies and medical records directly from Medicaid providers), and a review contractor (who will perform the medical and data processing review to determine if each claim was medically necessary and paid properly).

AdvanceMed is the assigned data documentation contractor with the responsibility of requesting and collecting provider's medical records to be used in the review process. Providers can expect to receive AdvanceMed documentation request letters beginning in February 2019. Additionally, BMS will be issuing advance reminder letters to all providers chosen by PERM to be part of the reviewed sample.

All Medicaid providers should be aware that they may be included in the records request process. If a provider receives a request of documentation for Medicaid billings, please be advised that it is imperative that all supporting documentation be submitted within the timeframe stated by AdvanceMed. Any requested documentation which is not received by AdvanceMed for review will be counted as an error against West Virginia Medicaid. This will result in a money payback for West Virginia Medicaid. If a provider does not respond to the documentation request to support their billings within the timeframe stipulated by AdvanceMed, that provider will have all outstanding Medicaid payments withheld until they have fully cooperated with the documentation request. Therefore, all Medicaid providers' full cooperation with the PERM process is requested by BMS.

If any West Virginia Medicaid provider has questions or concerns about the PERM process or their responsibility regarding the AdvanceMed documentation requests, please contact Lisa Landers at 304-356-4888.

Hepatitis A Outbreak

The State of West Virginia has been experiencing a hepatitis A outbreak since March 2018. This outbreak is molecularly linked to the multi-state outbreak in which genotype 1B is the concern. As of October 26, 2018, there have been a total of 1,774 reported cases, 914 hospitalizations, and five deaths related to the outbreak. Since June 2018, there has been an average of 70 new cases each week. The age range is from 12 to 86 years old, with the median being 37 years old. Currently, the most at-risk populations are people who use illicit drugs (75.2%), homeless persons or individuals with unstable housing (12%), people recently in jail, persons with chronic liver disease such as hepatitis B and/or C (62%), persons who provide direct services to those using illicit drugs or who are homeless, persons exposed to someone with hepatitis A, and anyone who has frequent contact with any of these populations. Currently, 36 out of 55 West Virginia counties have been affected by this outbreak.

To facilitate vaccination of these at-risk populations, DHHR's Bureau for Public Health has obtained hepatitis A vaccines and made them available for healthcare providers at no cost.

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Hepatitis A Outbreak (Cont.)

DHHR is encouraging Medicaid providers to universally screen and vaccinate their patients during routine medical visits. DHHR's Bureau for Public Health recommends **one dose** of the adult hepatitis A vaccine. One dose of hepatitis A vaccine has been shown to be effective when controlling an outbreak. Providers can acquire a screening tool and a vaccine request form for state-funded vaccine on the HepAware West Virginia website, www.hepawarewv.org, or by contacting the DHHR's Division of Infectious Disease Epidemiology at (304) 558-5358.

Encouraging patients to get vaccinated and to properly wash their hands is crucial to preventing the spread of hepatitis A. Remind patients to wash their hands with soap and running water before eating and after using the bathroom, as hand sanitizers will not kill the hepatitis A virus.

For more information, resources and outbreak updates, visit www.hepawarewv.org.

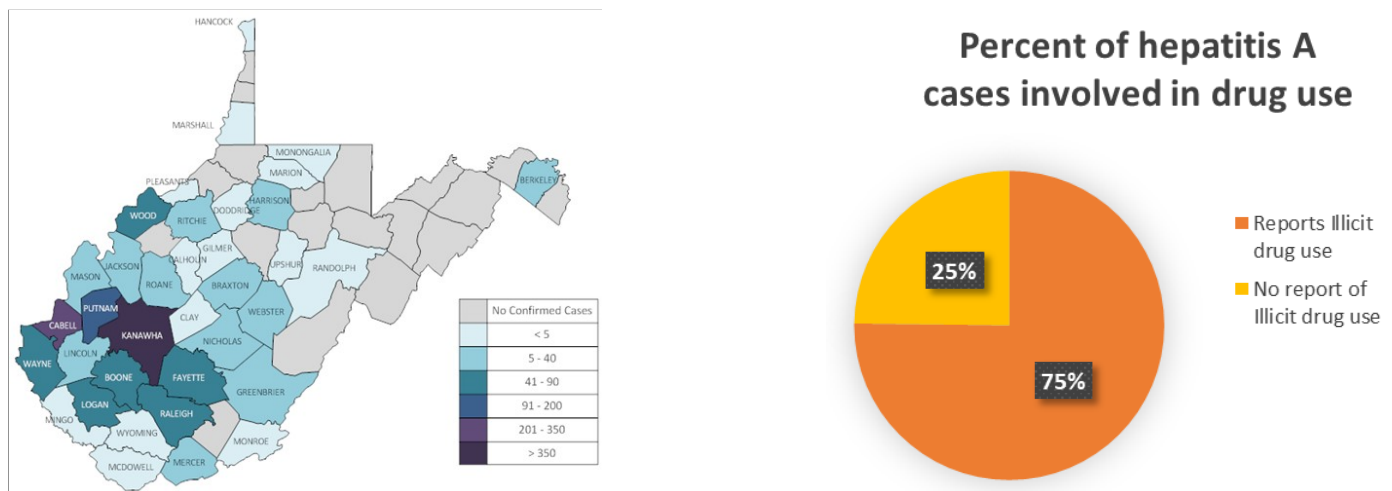


Figure 1. Number of confirmed hepatitis A cases in West Virginia by county

KEPRO Update

Effective July 1, 2018, West Virginia Medicaid made changes to the drug testing codes and their Medical Necessity Authorization limits.

- Medical Necessity Authorization is required in order to **EXCEED** 24 presumptive drug screens in a calendar year (1/1-12/31) - this includes CPT codes 80305, 80306 & 80307 in **combination**.
- Medical Necessity Authorization is required in order to **EXCEED** 12 definitive drug screens in a calendar year (1/1-12/31) - this includes HCPCS codes G0480, G0481 and, G0482 in **combination**.
Policy has been updated to require medical necessity authorization for G0483 and G0659 from the initial service in the calendar year.

KEPRO conducted two training webinars in July that cover these changes with providers. The PowerPoint presentation and the FAQs can be found on www.wvaso.kepro.com.

Registration with KEPRO is required to submit prior authorizations. Registration information can be found in the Drug Code Changes Webinar.

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KEPRO Update (Cont.)

For general questions, please call 1-800-346-8272 or e-mail wvmedicalservices@kepro.com. To obtain webinar materials go to www.wvaso.kepro.com.

To improve efficiency and decrease time needed to enroll when slots are released, BMS is modifying the agency selection process for Aged and Disabled Waiver (ADW) applicants.

- Applicants will make their Service Delivery Model (Traditional with Case Management Agency and Personal Attendant Agency or Personal Options) selection at the initial Pre-Admission Screening (PAS).
- Selections will be saved to the applicant's record in ADW CareConnection[®].
- When slots become available, referrals will be made based on the initial selections.
- Applicants will be able to transfer once they are enrolled.

For general questions, please call 844-723-7811 or email WVADWaiver@kepro.com.

Meet BMS Deputy Commissioner of Plan Management and Integrity

Fred Lewis has been appointed as the new BMS Deputy Commissioner of Plan Management and Integrity. In his position, he will oversee Pharmacy Services and Drug Rebate, Office of Program Integrity (OPI), and the Office of Managed Care Services.

Lewis has a vast background in state government since 1995. His began his tenure working for the Regular Legislative Session as session-hire where he undertook research under House Speaker Robert "Chuck" Chambers. Thereafter, he served as an auditor for the Performance Evaluation and Research Division in the Legislative Auditor's Office. Lastly, he served 18 years as a Policy Analyst for the House Committee on Finance working extensively on policy development and evaluation, the state budget and oversight issues under West Virginia Legislature Delegates Harold Chairmen Harold Michael, H.K. White, Brent Boggs and Eric Nelson.



Lewis' experience and understanding of state government has resulted in a smooth transition to BMS and its daily functions. In addition, the importance of providers' roles in West Virginia Medicaid.

"Like a river without water or a carnival without people, the balance of Medicaid would be pointless without its providers," says Lewis.

Lewis is committed to the earnest respect of provider decisions and needs, and to fostering better provider partnerships, integrity, and program quality as they are committed to West Virginia Medicaid members.

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Meet BMS Deputy Commissioner of Plan Management and Integrity (Cont.)

“One in three West Virginians count on our Medicaid providers to look after their well-being. Especially in our rural and economically disadvantaged areas, access to willing and appropriate providers can be difficult,” says Lewis.

Lewis is a Clarksburg, West Virginia native who graduated from Washington-Irving High School and earned a Bachelor of Science in Economics from WVU and a Masters in Science in Management with an emphasis in Health Care Administration from Marshall University.

Acute Care Hospitals Inpatient Prospective Payment System (IPPS) Update

The Office of Accountability and Management Reporting (OAMR), in its responsibility of Rate Setting and Provider Reimbursement for the BMS, has changed the timeline of updating the base amount for all acute care hospitals for inpatient care. In an effort to streamline the process, there will now be only one update on October 1st instead of two as in previous years. The July 1st base amount update will now coincide with the October 1st update of DRG weights. Please contact Leigh Ann Moore (OAMR) 304-356-4196 with any questions.

Fee Schedule Update

The following fee schedules will now be effective April 1st through March 31st starting in the calendar year (CY) 2019:

- Physician's (RBRVS) Fee Schedule
- Clinical Lab Fee Schedule
- Durable Medical Services
- Home Health Agencies
- Ambulatory Surgical Centers

BMS Welcomes New Non-Emergency Medical Transportation Broker

LogistiCare On September 1, 2018, LogistiCare became the new DHHR Non-Emergency Medical Transportation (NEMT) broker. The broker is contracted to provide excellent customer service and high-quality, safe, and reliable transportation for Medicaid members' covered services.

LogistiCare is the nation's leading manager of medical transportation programs for government agencies, managed care organizations (MCOs), self-funded insurers, hospitals, transit authorities and school boards. LogistiCare serves more than 24 million members in 41 states providing over 67 million trips in 238 programs.

Healthcare providers may call to schedule a trip for members at 844-889-1941 or online at: <https://tripcare.logisticare.com>.

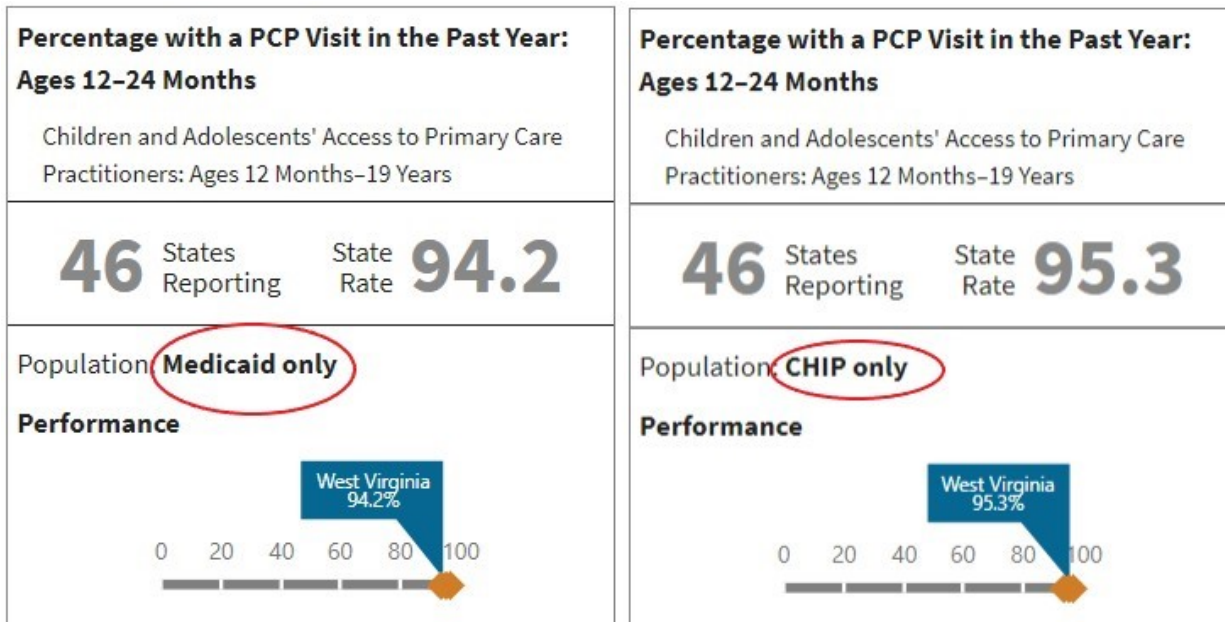
Quality Corner: CMS Releases First Quality Measure Scorecard

CMS recently released a Scorecard based on Medicaid data for Federal Fiscal Year (FFY) 2016. The data specifications for the Scorecard originated with the Medicaid Adult and Child Quality Core Measure Sets, which are produced by CMS annually.

CMS developed its Medicaid and the Children's Health Insurance Program (CHIP) scorecard to increase public transparency about the programs' administration and outcomes. The scorecard includes measures voluntarily reported by states, as well as federally reported measures.

While 50 states and territories reported on at least one measure, not all the states and territories reported on every measure. Based on the September 17 Medicaid/CHIP Fact Sheet, 50 states voluntarily reported at least one Child Core Set measure for FFY 2016 with 45 of these states reporting at least half (13) of the measures. The Fact Sheet also indicates that 41 states voluntarily provided data for the Adult Core Set with 31 states reported on at least half (14) of the measures.

States' data within the Scorecard is not 100% comparable "state-to-state" due to the capability of each state to meet reporting requirements. Also, there may be unique deviations from the CMS technical specifications for these Core Measures based on method of data extraction. Additionally, states may report on differing Medicaid and/or CHIP populations per measure which is noted on each individual statistic chart for the measure. States may have reported data for CHIP, Medicaid or a combination of both. States may also have differing Medicaid populations, e.g. expansion states vs non-expansion states. Below is an example of one of West Virginia's measures on the Scorecard that was reported separately by Medicaid and CHIP, i.e. not a combined rate. Please note, each population is circled in red.



Additional information including how to read the Scorecard is available on the CMS website:

<https://www.medicaid.gov/state-overviews/scorecard/index.html>.

Long-Term Care

Members who are eligible for Long-Term Care (LTC) services will have a different eligibility code. LTC claims will be denied if the member is not eligible for either of the following two Rate Codes:

- AMLTN
- AMLTI

Enrollments

Program/Benefit Name	Coverage Status	Coverage Level	Plan Type	Effective Date	Termination Date	Member ID
Medicaid Benefit Plan	Active	Secondary	Medical	01/01/2013	01/10/2018	00900290339
Coverage Code Description: Categorically Needy	Active			11/01/2017	01/10/2018	
Coverage Code Description: LTC	Active			12/29/2017	01/10/2018	
Coverage Code Description: Tier 1 Copay	Active			11/01/2017	01/10/2018	
Medicaid Benefit Plan	Active	Secondary	Medical	03/01/2017	01/10/2018	00900290339
Coverage Code Description: Qualified Medicare Beneficiary	Active			03/01/2017	01/10/2018	

Other Insurance

Claims Billing

- State billing policy concerning Worker Compensation Claims: Edit number 366 in our claim billing system is currently set to a “WARN” status. Effective October 1, 2018, this claim edit will be changed to a “DENY” status for all BMS State Programs. Please refer to DXC’s Web Portal announcements for a more detailed description.
- West Virginia Nursing and Long-Term Care facilities will encounter a change concerning current billing policy using the “M1” condition code requirement to bill partial resources. Currently, this condition code is being used to identify providers’ billing for a partial month, indicating that the Patient Responsibility will not match the Member Share-of-Cost when partial resource amounts are being billed. Beginning July 1, 2018, claims with the above condition code will return the “WARN” status on the remittance advice. Providers currently using “M1” condition code should change to Value Code “D3”. During this notification period, DXC’s system will accept both “M1” and “D3” codes and will return a “WARN” edit. Effective October 1, 2018, claims will “DENY” unless billed with the “D3”. No retro claim adjustments will be processed. Please call DXC’s Providers Services number at 888-483-0793 or email LTC@MolinaHealthcare.com with questions.

DXC Update: Provider Enrollment News

The federally required enrollment revalidation process is in full swing. DXC is reminding providers that you must complete and submit your revalidation before the 120 day deadline in order to avoid your file being termed in our system. If this occurs, you will not be able to submit claims or receive payment.

The enrollment process has evolved over the last few years and we are able to extract provider licensures from the governing board websites. However, there are still a few provider types we are unable to access. It is the provider's responsibility to submit an updated license **prior to the expiration date** to avoid any disruption in your ability to receive reimbursement for covered services. If you have questions about submitting updated licensures, contact Provider Enrollment at: WVProviderEnrollment@molinahealthcare.com.

Affected provider types include:

- Therapists (Speech, Physical, and Occupational)
- Transportation including Emergency Medical Transportation
- Licensed Professional Counselors
- BCBA and BCABA

DXC Update: Provider and Member Services News

The implementation of the federally required unenrolled prescriber initiative concerning all prescriptions was a success. Our covered members experienced minimal disruption to receiving their prescribed medication. DXC Technology would like to send a special thank you to our participating pharmacies for the professional collaboration on troubleshooting any denied claims for patients at the point of sale.

DXC would like to remind all provider offices of the web chat functionality. You can chat in real time with a live Provider Services Representative.

DXC Call Center has been receiving an increase of request for copies of Remittance Advices. Providers should use the portal to access their remittance advice notices. WVMMIS@molinahealthcare.com

The Coding Corner

The 2019 Current Procedural Terminology (CPT) code set includes 335 code changes. These include three new remote patient monitoring codes that reflect how health care professionals can more effectively and efficiently use technology to connect with their patients at home and gather data for care management and coordination. Medicare's acceptance of the new codes would signal a landmark shift to better support physicians participating in patient population health and care coordination services that can be a significant part of a digital solution for improving the overall quality of medical care. All 335 codes changes are currently under review by West Virginia Medicaid. The 2018 ICD10 that were effective October 1, 2018 includes 363 new codes, 142 deletions and 226 code revisions.

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), Bureau for Public Health (BPH), and DXC Technology.

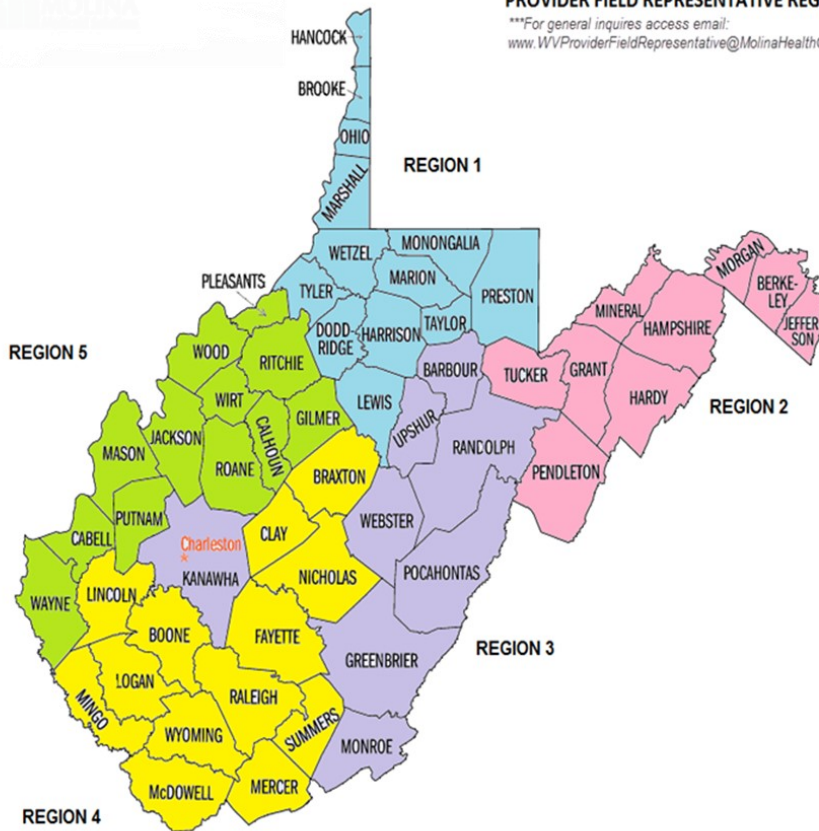
Bill J. Crouch, DHHR Cabinet Secretary
 Jeremiah Samples, DHHR Deputy Secretary
 Cynthia E. Beane, DHHR BMS Commissioner

Contributing writers: Margaret Brown, Dee Ann Price, Leon Smith, Amy Sutton and Scott Winterfeld - BMS, Sierra Hall - KEPRO, Catherine Lewis - BPH, Angela Stanley and Karen Hoylman - DXC.



PROVIDER FIELD REPRESENTATIVE REGION MAP

***For general inquires access email:
www.WVProviderFieldRepresentative@MolinaHealthCare.com



- Region 1 Representatives:**
 Linda Pennington at Linda.Pennington@MolinaHealthCare.com
 Millie Carter at Camilla.Carter@MolinaHealthCare.com
- Region 2 Representative:**
 Debbie Rhodes at Deborah.Rhodes@MolinaHealthCare.com
- Region 3 Representatives:**
 Katrena Edens at Katrena.Edens@MolinaHealthCare.com
 Michelle Miller at Michelle.Miller2@MolinaHealthCare.com
- Region 4 Representatives:**
 Gloria Hayes at Gloria.Hayes@MolinaHealthCare.com
 Tonya Ball at Tonya.Ball@MolinaHealthCare.com
- Region 5 Representatives:**
 Whitney Choyce at Whitney.Choyce@MolinaHealthCare.com
 Brandon Treola at Brandon.Treola@MolinaHealthCare.com

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Contact

DXC Technology

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

DXC 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.

DXC Provider FAX
304-348-3380

DXC 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. BBH

DXC 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

DXC 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:

**DXC Technology
PO Box 625
Charleston, WV 25337**

Claims Information

To expedite timely claims processing for DXC, 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.