West Virginia Medicaid
Pharmacy Solutions

BMS MEDIWEB PORTAL

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West Virginia Medicaid Pharmacy Department

http://www.dhhr.wv.gov/bms/Pharmacy

Provider Services

888-483-0793

888-483-0801 (Pharmacy)
304-348-3360
Monday – Friday
8:00 am until 5:00 pm

Pharmacy Help Desk& Pharmacy Prior Authorization (Rational Drug Therapy Program)

800-847-3859 (Phone)

800-531-7787 (Fax)
Monday – Saturday
8:30 am until 9:00 pm
Sunday 12:00 pm until 6:00 pm

Member Services

888-483-0797
304-348-3365
Monday – Friday
8:00 am until 5:00 pm

Preferred Drug List

For a copy of the most recent preferred drug list, visit:

http://www.dhhr.wv.gov/bms/Pharmacy/Pages/pdl.aspx

State Maximum Allowable Cost (SMAC)

SMAC Review Form:

http://www.dhhr.wv.gov/bms/Pharmacy/Pages/smac.aspx

Please refer questions to Magellan at 1-800-763-7382 or e-mail to StateSMACProgram@magellanhealth.com.

Medicaid Expansion News

Traditionally, Medicaid has served pregnant women, children, low income families, medically-needy individuals and those who are aged, blind, or disabled. Starting October 1, 2013, Medicaid coverage will expand to individuals between the ages of 19 and 64 and former West Virginia foster children who fall within 138 percent of the Federal Poverty Line.

Today, a family of four can only earn up to approximately $3,700 a year in order to qualify for Medicaid. After October 1, this same family can earn up to approximately $32,000 a year and still qualify for Medicaid coverage.

The Medicaid expansion population will be enrolled into *The Health Bridge Plan – My Healthcare Connection,* a managed care program. Providing benefits through managed care improves the quality of care for Medicaid members by coordinating all aspects of health care and through accreditation and contractual monitoring. Managed care also helps the State to better control health care costs and create a predictable budget for the State.

Part of the Affordable Health Care Act of 2010 was to set up a "no wrong door" approach for applying for health care insurance, whether through a private insurance plan or Medicaid. Individuals may apply

- On-line at the Health Insurance Marketplace at www.HealthCare.gov;
- On-line at www.wvinRoads.org;
- At his/her local West Virginia Department of Health and Human Resources (DHHR) office;
- By mail to the local DHHR office; and
- By calling the Federal Call Center at 1-800-318-2596.

There will also be navigators and in-person assisters in local communities to help people with the application process.

The CCRC Actuaries report commissioned by the West Virginia Office of the Insurance Commissioner estimates that, by 2018, more than 90,000 additional West Virginians will be enrolled in the Medicaid and WVCHIP programs. Expanded coverage through Medicaid will begin on January 1, 2014.

West Virginia Medicaid Policy Around Buprenorphine Assisted Detox

As a reminder of the policy, highlights are listed here. For more detailed information, please visit the State's Website: http://www.dhhr.wv.gov/bms/news/Pages/SuboxoneandSubutexCoverageInformation.aspx

Please note that, at this time in West Virginia, only those prescribers who are licensed physicians (Medical Doctor [MD] or Doctor of Osteopathic Medicine [DO]) with a valid DEA "X" number may write for this medication. Detailed criteria follow. **Prescribers must**

1. Evaluate patients before requesting and/or beginning drug therapy. A staff member other than the prescriber may complete this initial evaluation; however, no medication may be given before the prescriber has done his/her own evaluation.
2. Request the prior authorization (PA) in writing on the designated PA form via fax or electronic submission. The PA fax form can be found at http://www.dhhr.wv.gov/bms/news/Pages/SuboxoneandSubutexCoverageInformation.aspx.
3. In addition to being a licensed physician with a degree as a MD and/or DO, the prescriber must also be; board certified; in good standing in the State of West Virginia; qualified for a waiver under the Drug Addiction Treatment Act (DATA); has notified the Center for Substance Abuse Treatment of the intention to treat addiction patients; and has been assigned a DEA (X) number. The prescriber must be included on the DATA Physician locator.
4. Be a West Virginia Medicaid enrolled provider (enrolled directly, enrolled with a Managed Care Organization [MCO], or be employed by a facility that is enrolled with West Virginia Medicaid) who certifies he or she is treating the patient for addiction issues and is billing West Virginia Medicaid for this service.

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5. Complete an attestation that the Board of Pharmacy Prescription Drug Monitoring Program database has been reviewed for other drug use, including benzodiazepines, sedative/hypnotics, and opioids.
6. Warn patients of the dangers of ingesting sedating medications while taking buprenorphine.
7. Agree to adhere to the Coordination of Care Agreement that will be signed by the patient, the treating physician, and the treating therapist. This agreement must be retained in medical records and updated annually. If a change in provider occurs, a new agreement must be signed.
8. Perform a minimum of two random urine drug screens per month on the patient and maintain these results in the patient's medical record. The drug screen must test at a minimum for the presence of; opiates, oxycodone, methadone, buprenorphine, benzodiazepines, PCP/LSD, amphetamines, methamphetamine, and alcohol.
9. As a reminder, buprenorphine products have the following limits. **Dosing/Prescription limits include**
   - The maximum initial dose is 24 mg per day for a maximum of 60 days and limited to once per lifetime.
   - The maximum maintenance dose is 16 mg per day.
   - Early refills are not permitted, including replacement of lost or stolen medication.

Timely Billing

Please note that all claims billed to the Fee-for-Service Medicaid Program for members who are enrolled in Medicaid Managed Care Plans must be re-billed to the MCO within 90 days of the date of service. This policy reflects Section §438.60 of the Social Security Act (Title XIX) which states that no payment may be made to a provider other than the MCO for services available under the contract with the MCO.

West Virginia Medicaid will reverse any pharmacy claims billed for MCO members, but pharmacies are responsible for re-billing. Letters are being sent to all pharmacy providers to alert them of the need to rebill. Please be on the lookout for letters from Molina Medicaid Solutions in order to take advantage of the opportunity to rebill these claims.

Upcoming Preferred Drug List (PDL) Changes

Please be aware there was not a Pharmacy & Therapeutics Committee meeting this quarter, so there are no significant changes to the PDL to report at this time. The complete PDL with criteria is available on the Bureau's website at http://www.dhhr.wv.gov/bms/Pharmacy/Pages/pdl.aspx. Thank you for helping West Virginia Medicaid members maintain access to prescription coverage by selecting drugs on the preferred drug list whenever possible.

Acetaminophen Labeling Change to Include New Warning

The U.S. Food and Drug Administration (FDA) is requiring that a warning be added to the labels of prescription drug products containing acetaminophen to address the risk of serious skin reactions.

The FDA regulates over-the-counter (OTC) products containing acetaminophen differently from prescription products so the Agency will work with OTC manufacturers to address this safety issue separately. Acetaminophen has been associated with a risk of rare but serious skin reactions. These skin reactions, known as Stevens-Johnson Syndrome (SJS), toxic epidermal necrolysis (TEN), and acute generalized exanthematous pustulosis (AGEP), can be fatal. Reddening of the skin, rash, blisters, and detachment of the upper surface of the skin can occur with the use of drug products that contain acetaminophen. These reactions can occur with first-time use of acetaminophen or at any time while it is being taken. Please advise your patients accordingly.

OIG Guidance on Excluded Providers

In May of this year, the Office of Inspector General (OIG) released an update to their original guidance dated 1999. The updated advisory gives more detailed explanation on the scope and effect of the legal prohibition on payment by Federal health care programs to parties on the exclusion lists; List of Excluded Individuals and Entities (LEIE), General Services Administration (GSA) System for Award Management (SAM), and other lists such as the National Practitioner Data Bank (NPDB). This new advisory replaces and supersedes the bulletin from 1999.

In 1981, the Civil Monetary Penalties Law (CMPL) was enacted. It authorized the imposition of civil money penalties (CMPs), assessments, and program exclusions against any party that submits false or fraudulent or other improper claims for Medicare or Medicaid payment. In 1996, the Balanced Budget Act (BBA) in conjunction with HIPAA expanded the sanction authority of the OIG to also include entities that employ or contract with an excluded person.

OIG exclusion means that no Federal health care program payment may be made for any items or services furnished by an excluded person or under the medical direction or on the prescription of an excluded person, even if the excluded person changes to another health care profession. Example; services performed by excluded pharmacists, or other excluded persons who input prescription information for pharmacy billing or who are involved in any way with filling prescriptions that are billed to a Federal health care program. Excluded persons are prohibited from furnishing management/administrative services, as well. Examples; an excluded person may not serve in any executive or leadership role, nor provide information technology services, accounting, training, or human resources services for a provider that receives payment from a Federal health care program. Liability may result even if the excluded person performs services for which they receive no payment. Example; an excluded person who performs volunteer services for a health care provider, puts the provider at risk for sanctions. The risk for employing or contracting or accepting volunteer services from an excluded person consists of a CMP of $10,000 for each claim or service furnished during the time the person was excluded. Violations may also include criminal or civil actions in addition to the CMP.

The OIG started the LEIE in 1999 to assist providers in verifying parties who are excluded. At a minimum, OIG recommends screening all contractors, employees, potential employees, and temporary staff from staffing agencies monthly. The provider should also maintain documentation of the screenings (printed screen shots showing results of name searches).

Resources: http://oig.hhs.gov/exclusions; https://www.sam.gov; http://www.npdb-hipdb.hrsa.gov/;
Full OIG advisory: http://oig.hhs.gov/exclusions/files/sab-05092013.pdf