

Pharmacy Benefits Moving from Managed Care to Fee-For-Service

Effective July 1, 2017, the pharmacy (Rx) benefit for West Virginia Medicaid members enrolled in a Managed Care Organization (MCO) will move back to the traditional fee-for-service (FFS) program. The transition is expected to generate significant savings in Rx savings due to a reduction in program administration costs and modifications to the ingredient and dispensing cost formulas. The State will set a minimum dispensing fee, which will result in higher revenue to pharmacies, and ultimately, the State economy.

All prescriptions should be billed with the information below:

- BIN 610164
- PCN DRWVPROD

Questions regarding claims processing should be directed to the Molina Point-of-Service Pharmacy help desk at 888-843-0801. The vendor specification document can be found on the Molina website at www.wvmmis.com for information regarding claims processing.

The Molina claims processing will accept only the member's West Virginia Medicaid Identification Number (MAID) that is printed on the member's MCO card or on the member's traditional, blue Medicaid card. The MAID is 11 digits and generally begins with a zero. Call Molina automated voice response system at 888-483-0801 for confirming the MAID and eligibility verification.

Requests for prior authorization or claim edit overrides should be directed to the Rational Drug Therapy Program by fax at 800-531-7787 or by phone at 800-847-3859.

Nursing home providers batch billing must be adjudicated before 11:59 p.m. on July 1, 2017. Claims for MCO members submitted with a date of service before July 1, 2017, will be denied by the fee-for-service pharmacy program and will not be accepted by the MCO pharmacy benefits managers after 12:01 a.m.

Fall Provider Workshops Dates and Locations

The April 2017 Spring workshops had more than 600 providers in attendance. The presentations are posted on the Molina portal at www.wvmmis.com/WV%20Provider%20Workshops/Forms/AllItems.aspx.

We look forward to seeing you in the Fall on the below dates. Please mark your calendar now!

- September 18, 2017 - Flatwoods
- September 19, 2017 - Charleston
- September 20, 2017 - Huntington
- September 21, 2017 - Beckley
- September 25, 2017 - Martinsburg
- September 26, 2017 - Morgantown
- September 27, 2017 - Wheeling
- September 28, 2017 - Parkersburg

Meet Bureau for Medical Services Commissioner Cynthia Beane

Cynthia Beane was appointed Commissioner of the Bureau for Medical Services (BMS) in May 2017 by West Virginia Department of Health and Human Resources (DHHR) Cabinet Secretary Bill J. Crouch.

Commissioner Beane, MSW, LCSW, has more than 19 years of experience working with health care in both the public and private sector. Her vast experience has allowed her to hold various positions at DHHR. Prior to her assuming the role of Commissioner, she served as Acting Commissioner for BMS for the past three years. In addition, she served as Deputy Commissioner of Policy Coordination for BMS where she managed and oversaw the development and implementation of health policy for the State Medicaid population. Moreover, she led changes to policy implementation due to the Affordable Care Act.



Commissioner Beane managed BMS project development and assured compliance with state and federal policy through her previous position as the Director for Policy and Administrative Services. In this position, she managed and administered provider enrollment, Medicaid fair hearings, bureau purchasing and contracts, policy development, grants management and affiliated programs.

She has extensive experience in mental health program policy development and development of home and community-based programs. While working with a large rehabilitation facility, she served as a Case Manager and as the Community Coordinator and Director of a day treatment program for more than 85 individuals with developmental disabilities. Commissioner Beane assured compliance with all state and Medicaid regulations, monitored treatment and documentation for quality assurance, completed assessments and developed programs and behavioral support plans.

Commissioner Beane is a Licensed Certified Social Worker who holds a Bachelor of Arts degree in Education from Marshall University and a Master of Social Work from West Virginia University.

Commissioner Beane has been married to her husband Brian for 24 years and they have two children, Lindsey and Wyatt.

The Future of West Virginia Medicaid ID Cards

In 2015, West Virginia Medicaid identification (ID) cards were transitioned from a monthly card to a card generated on an annual basis. At that time, more than half of the Medicaid members were enrolled in fee-for-service (traditional) Medicaid. Now, approximately 80% of Medicaid members are enrolled in managed care organizations (MCOs) and receive both an annual Medicaid ID card plus an MCO ID card. The West Virginia Department of Health and Human Resources (DHHR) continues to explore options to streamline the delivery method of Medicaid eligibility and billing information.

Presented at the Spring 2017 Provider Workshops was a proposal to disseminate Medicaid coverage information to all members in a format other than the annual Medicaid ID card. The post-workshop survey contained questions related to verification of Medicaid eligibility. From the 629 provider workshop attendees (based on sign-in logs), at least 404 responses were received for each survey question. While the survey results are small compared to the number of Medicaid enrolled providers, they suggest that ID cards may no longer be necessary.

Ninety-nine percent (99%) of survey responses reflect that internet access is available in their practice setting. Nearly three-fourths (73%) of the responses to the question “*What percentage of Medicaid members bring their identification cards with them to their appointment?*” indicate that less than 50% of Medicaid members bring their ID cards to appointments. Most provider representatives responded that eligibility is verified via Molina’s provider portal or automated voice response system (AVRS).

Watch for additional information about innovations in this area on the Bureau for Medical Services and Molina websites as well as in upcoming Provider Newsletters and in presentations at the Fall 2017 Provider Workshops.

Five Ways for Health Care Providers to Get Ready for New Medicare Cards

Medicare is taking steps to remove Social Security numbers from Medicare cards. Through this initiative, the Centers for Medicare and Medicaid Services (CMS) will prevent fraud, fight identity theft, and protect essential program funding and the private health care and financial information of Medicare beneficiaries.

CMS will issue new Medicare cards with a new unique, randomly-assigned number called a Medicare Beneficiary Identifier (MBI) to replace the existing Social Security-based Health Insurance Claim Number (HICN) both on the cards and in various CMS systems. New cards will start to be mailed to people with Medicare benefits in April 2018. All Medicare cards will be replaced by April 2019.

CMS is committed to helping providers by giving them the tools they need to make this change. Based on feedback from health care providers, practice managers, and other stakeholders, CMS is developing capabilities so that providers will be able to look up the new MBI through a secure tool at the point of service. To make this change easier, there is a 21-month transition period where all health care providers will be able to use either the MBI or the HICN for billing purposes.

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Five Ways for Health Care Providers to Get Ready for New Medicare Cards (Cont.)

Therefore, even though provider systems will need to be able to accept the new MBI format by April 2018, providers can continue to bill and file health care claims using a patient's HICN during the transition period. We encourage providers to work with their billing vendor to make sure that their system will be updated to reflect these changes.

There are five steps you can take today to help your office or health care facility get ready for this change:

1. Go to the CMS provider [website](#) and [sign-up](#) for the weekly MLN Connects[®] newsletter.
2. Attend CMS [quarterly calls](#) to get more information. CMS will let you know when calls are scheduled in the MLN Connects newsletter.
3. Verify all of your Medicare patients' addresses. If the addresses you have on file are different than the Medicare address you get on electronic eligibility transactions, ask your patients to contact [Social Security](#) and update their Medicare records.
4. Work with CMS to help your Medicare patients adjust to their new Medicare card. When available later this fall, you can display helpful information about the new Medicare cards. Hang posters about the change in your offices to help CMS spread the word.
5. Test your system changes and work with your billing office staff to be sure your office is ready to use the new [MBI format](#).

CMS will keep working closely with you to answer your questions and hear your concerns. To learn more, visit: cms.gov/Medicare/SSNRI/Providers/Providers.html.

West Virginia Medicaid: Looking to Utilize Quality Measures Data for Future Planning and Direction

For the past four years, West Virginia Medicaid's Quality Unit has been looking at health care quality data in a new light. Since being awarded the Centers for Medicare and Medicaid Services (CMS) Adult Medicaid Quality (AMQ) Program Grant in 2012, the Quality Unit has been responsible for reporting CMS-selected Core Measures data to CMS. This program was designed by CMS to support state Medicaid agencies in developing staff capacity to collect, report, and analyze data gathered on a set of health care quality measures deemed vital to understanding and acting on current health trends. According to CMS, "The core sets are tools states can use to monitor and improve the quality of health care provided to Medicaid enrollees. Under statute, states reporting on these measure sets is voluntary. The goals of this effort are to encourage national reporting by states on a uniform set of measures and to support states in using these measures to drive quality improvement."

The basis for the yearly core measures selection by CMS are for measures that encompass areas deemed vital to health care management and, according to CMS, focus primarily on six domains: prevention and health promotion, management of acute conditions, management of chronic conditions, family experiences of care, care coordination/care transitions, and availability. While reporting of the measures to CMS is voluntary for state Medicaid agencies, West Virginia Medicaid has decided to continue reporting the measures data even after the AMQ grant award ends in December 2017. The data collected from these measures will help West Virginia and CMS to better understand the quality of health care that adults and children enrolled in Medicaid receive.

State Plan Amendment (SPA) Update: Cardiac and Pulmonary Rehabilitation Services

The West Virginia Department of Health and Human Resources (DHHR), Bureau for Medical Services (BMS) has offered both cardiac and pulmonary rehabilitation services to eligible Medicaid members for a number of years as part of West Virginia's 1937 Benchmark Plan. However, due to the January 1, 2014 removal of this benchmark plan, State Plan Amendments (SPAs) were submitted to outline the service descriptions, provider qualifications, and payment methodology for the provision of these services. On April 11, 2017, the Centers for Medicare and Medicaid Services (CMS) approved these SPAs with a January 1, 2014 effective date.

SPA 14-004 addresses cardiac rehabilitation services. Cardiac rehabilitation is a comprehensive outpatient program of medical evaluation, prescribed exercise, cardiac risk factor modification and education and counseling that is designed to restore members with heart disease to active, productive lives. A supervising physician recommends an individually tailored multidisciplinary approach based on an assessment and plan of care designed to promote reduction of physical disability and restore members to the best possible functional level and active productive lives. The plan of care identifies what services are needed, which professionals should provide the services, how often the member will need the services, and the results expected from the treatment. The plan of care is updated every six weeks. Services include, but are not limited to:

- 36 sessions of supervised exercise by an exercise physiologist, which can be exceeded based on medical necessity.
- Member training and education performed by nurses, nurse practitioners and/or physician assistants, which consists of disease specific education to the beneficiaries based on their medical conditions.
- Nutrition counseling performed by a licensed dietician. This would involve specific counseling on dieting to address issues such as cholesterol levels, dietary sodium levels, weight control and reduction and diabetes control.
- Mental health counseling to members to address depression or other mental health conditions associated with cardiac disease. These services are provided by mental health professionals.

SPA 14-005 addresses pulmonary rehabilitation. Pulmonary rehabilitation is an individually tailored multidisciplinary approach to the rehabilitation of Medicaid members based on an assessment and plan of care, to promote reduction of physical disability and restore beneficiaries to the best possible functional level and active productive lives. The plan of care includes identifying what services are needed, which professionals should provide the services, how often the member will need services and the results expected from the treatment. The plan of care is updated every six weeks. Services include, but are not limited to:

- Exercise physiology services performed by an exercise physiologist, based on a physical activity plan tailored to the member's needs, which includes strengthening and conditioning which may include stair climbing, inspiratory muscle training, treadmill walking, and cycle training designed to improve the member's lung strength to better enable him/her to carry out daily activities.
- Respiratory therapy performed by a respiratory therapist to include breathing retraining, which involves learning how to take longer, deeper, less frequent breaths and bronchial hygiene, which is a set of methods used to clear mucus and secretions from the airways.

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State Plan Amendment (SPA) Update: Cardiac and Pulmonary Rehabilitation Services (Cont.)

- Member training and education performed by nurses, nurse practitioners and/or physician assistants, which consist of disease specific education to the beneficiaries based on their medical conditions.
- Nutrition counseling performed by a licensed dietician. This would involve specific counseling on dieting to address issues such as cholesterol levels, dietary sodium levels, weight control and reduction and diabetes control.
- Mental health counseling involving counseling to members to address depression or other mental health conditions associated with pulmonary disease. This service is provided by mental health professionals.

For more information on cardiac and pulmonary rehabilitation go to:

[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).

KEPRO Update: T-Codes

As of May 1, 2017, the code T4535 has been added to the KEPRO production system. Due to the concerns from providers regarding the members' needs for disposable liners, shields, guards, and pads for incontinence, BMS has opened this new code for prior authorization and billing purposes.

For more information regarding this new code, please visit www.wvaso.kepro.com and go to the resources page where you can find more details regarding this update along with many others that have been recently completed.

For your convenience, KEPRO's main contact numbers are listed below:

KEPRO Department	Telephone Number
Main Line	1-304-343-9663
Behavioral Health	1-800-378-0284
I/DD and TBI Waiver	1-866-380-0617
Aged and Disabled Waiver	1-844-723-7811
Personal Care and Nursing Home	1-844-723-7811
Social Necessity	1-800-461-9372
Medical Department	1-800-346-8272

Managed Care Update

The Bureau for Medical Services (BMS) will not be performing a quality withhold in State Fiscal Year (SFY) 2018. As a result, no funds will be attached to meeting select Healthcare Effectiveness Data and Information Set (HEDIS) measures.

Substance Use Disorder (SUD) Waiver Program Gets New Program Manager

Jeff Lane has been appointed Program Manager for the Bureau for Medical Services (BMS) new Substance Use Disorder (SUD) Waiver program. Lane has a vast professional background in substance use disorders. Prior to his new position, Lane served as a substance abuse counselor for the Assertive Community Treatment team at Logan-Mingo Area Mental Health Inc. In addition, he served as a West Virginia State Probation Officer and was a three-term Magistrate for his home county of Logan.



Lane is very excited to see how the SUD Waiver program impacts West Virginians and hopes its services will help eradicate the current substance abuse crisis occurring in the State. “The SUD Waiver program looks forward to expanding services for our providers. It will allow them to better treat our Medicaid members and assist them in reaching recovery,” says Lane. West Virginia Department of Health and Human Resources (DHHR), BMS is still negotiating with the Centers for Medicare and Medicaid Services regarding the provisions of the SUD Waiver.

Services that will be expanded through the SUD Waiver program include:

- Screening, brief intervention and referral to treatment (SBIRT)
- Intensive outpatient services (IOP)
- Partial hospitalization services
- Clinically managed low-intensity residential services
- Clinically managed population-specific, high-intensity residential services (adult only)
- Clinically managed high-intensity residential services (adult only)
- Medically monitored high-intensity inpatient services
- Medically managed intensive inpatient services
- Ambulatory withdrawal management without extended on-site monitoring (outpatient withdrawal management)
- Ambulatory withdrawal management with extended on-site monitoring (outpatient withdrawal management)
- Medically managed intensive inpatient withdrawal management
- Recovery supports
- Peer supports

These services are offered with a goal to build a comprehensive continuum of care across the State to help prevent and treat substance use disorders more effectively in the State. Lane shares the same goals and will apply his skills and experience to the new program as he wants to eradicate this crisis that his home State is experiencing.

Lane is a Logan, West Virginia native who holds a Bachelor of Arts in Psychology from Marshall University and two master’s degrees in Counseling and Justice Leadership from the former West Virginia College of Graduate Studies (WVCOGS), which is now Marshall University’s Graduate School.

Coding Corner

Effective September 1, 2017, the service limit for the following Current Procedural Terminology (CPT) codes will change for West Virginia Medicaid.

92133 - Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve. Currently, 92133 has a limit of one per day and will be changed to one per year. Additional units must be prior authorized.

92134 - Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina. Currently, 92134 has a limit of one per day and will be changed to four per year. Additional units must be prior authorized.

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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Provider Field Representative Region Map

County Health Departments and ALL School Based Services (All 55 counties)

Joy Dalton

Email: Joy.Dalton@Molinahealthcare.com

Phone: 888-562-5442 ext. 252779

Region 5: Cary Johnson
Email: Cary.Johnson@Molinahealthcare.com
Phone: 888-562-5442 ext. 253277

Region 5: Christina Martin
Email: Christina.Martin@Molinahealthcare.com
Phone: 888-562-5442 ext. 253245

Region 1

Region 1: Debbie Rhodes
Email: Deborah.Rhodes@Molinahealthcare.com
Phone: 888-562-5442 ext. 253246

Region 5

Region 2

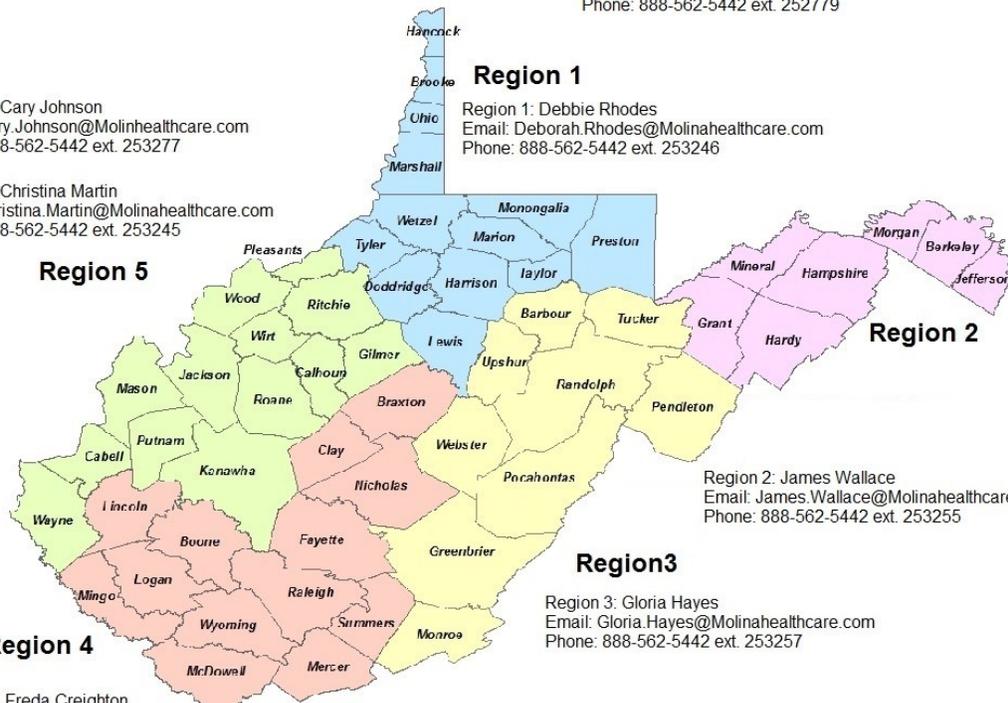
Region 2: James Wallace
Email: James.Wallace@Molinahealthcare.com
Phone: 888-562-5442 ext. 253255

Region 3

Region 3: Gloria Hayes
Email: Gloria.Hayes@Molinahealthcare.com
Phone: 888-562-5442 ext. 253257

Region 4

Region 4: Freda Creighton
Email: Freda.Creighton@Molinahealthcare.com
Phone: 888-562-5442 ext. 253251



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 are at Charleston, WV 25337

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 any suggestions on how we can improve the portal to make it more user friendly, please contact our EDI helpdesk at: edihelpdesk@molinahealthcare.com.