Housekeeping Rules For Attendees

- Please make sure your phone is on mute.
- Please make sure you type your questions in the chat box.
- Questions will be answered at the end of the presentation during the Q&A session.
- A copy of the presentation is available on the WVMMIS Health PAS On-Line Portal www.wvmmis.com
2022 Virtual Spring Provider Workshops

Morning Session
General Overview, Appeals
Process, Chiropractic Updates
Portal & Claim Webinar dates

Afternoon Session
Behavioral Health Updates
Enrollment of New Provider Types
COVID Policy Evaluation

Dates and Times
Tuesday, April 19 from 9:00-12:00
Thursday, April 21 from 9:00-12:00
Wednesday, April 27 from 9:00-12:00

Dates and Times
Wednesday, April 20 from 1:30-3:30
Tuesday, April 26 from 1:30-3:30
Thursday, April 28 from 1:30-3:30

Registration Link
https://www.surveymonkey.com/r/WVCP738

Questions?
WVProviderFieldRepresentative@GainwellTechnologies.com
Spring 2022
Provider Virtual Workshops

Diana Bossie, Interim Director
Medicaid Management Information Systems (MMIS)
Provider Workshops Schedule

Morning Session Topics:
- General overview, appeals and process
- Chiropractic updates
- Telehealth update
- Portal and claim webinar dates

Afternoon Session Topics:
- Behavioral health updates
- Enrollment of new provider types
- COVID-19 policy evaluation

Morning Session Dates:
- April 19, 9:00 a.m. – 12 p.m.
- April 21, 9:00 a.m. – 12 p.m.
- April 27, 9:00 a.m. – 12 p.m.

Afternoon Session Dates:
- April 20, 1:30 p.m. – 3:30 p.m.
- April 26, 1:30 p.m. – 3:30 p.m.
- April 28, 1:30 p.m. – 3:30 p.m.
Due to the World Health Organization’s declaration of Coronavirus disease 2019 (COVID-19) as a pandemic, the West Virginia Department of Health and Human Resources (DHHR) continues to provide no-cost testing for all West Virginia residents, regardless of their insurance status.

- Billing for Medicaid, West Virginia Children’s Health Insurance Program (WVCHIP), uninsured and privately insured available through Medicaid.
- Effective December 4, 2020, the rate for specimen collections codes increased to $25.
COVID-19 Vaccine Update

- Vaccine codes pay at $0 (these are provided free of charge by the federal government).

- Effective for COVID-19 vaccines administered on or after March 15, 2021, the national average payment rate for physicians, hospitals, pharmacies, and many other immunizers changed to $40 to administer each dose of a COVID-19 vaccine.
During the Public Health Emergency (PHE) Declaration, Medicaid had a continuous eligibility provision.

Although eligibility redeterminations/renewals were conducted as usual, those who failed to complete a renewal or were determined ineligible, were coded to remain eligible during the PHE. There are currently 100,000+ individuals with this continued coverage.

Once the PHE ends, these individuals will be scheduled for a final renewal at some point during the 12-month “unwinding period.”

Closures for anyone who fails to complete a renewal or is determined to be ineligible will begin at the end of the month following the end of the PHE.

For example, if the PHE ends in July 2022, the first closures will happen in August with a July 1, 2022, effective date.
In preparation for the end of the PHE Declaration and the continuous eligibility provision, West Virginia Medicaid has been working on a three-phase communication approach.

- **Phase One:** West Virginia Medicaid must have the most up-to-date contact information for members to assure they will receive renewal notices. West Virginia Medicaid is focusing on outreach and your help is needed.

- **Phase Two:** This phase will begin when West Virginia Medicaid receives the 60-day notice that the PHE will end. Renewal letters will be mailed out to those who previously failed to complete a renewal or were determined ineligible during the PHE. It is important that members understand they need to renew their coverage.

- **Phase Three:** This phase will begin when the PHE had ended. Coverage for uninsured testing will end with the PHE. Closures for members will begin the month following the end of the PHE.
As of March 2022, 630,801 West Virginians received coverage (approximately 35% of West Virginia’s population).

- Fee-For-Service (FFS), i.e., traditional/regular Medicaid:
  - 116,877 members are currently enrolled.
    - Includes most Medicaid Waiver recipients; nursing facility residents; elderly/disabled; transplant recipients; individuals who receive Medicare; and those who receive Health Insurance Premium Payment (HIPP) program.

- Mountain Health Trust (MHT), West Virginia’s Medicaid Managed Care Program:
  - 513,924 members are currently enrolled.
    - Includes eligible children, including those in foster care, adopted, or Children with Serious Emotional Disorder Waiver (CSEDW) participants; pregnant women; adult expansion; parents and caretaker relatives; and Supplemental Security Income (SSI) recipients.
West Virginia Medicaid and WVCHIP providers, please remind your patients that have moved or had their address changed by 911 to update their address with DHHR’s Customer Service Center or it may affect their benefits in the future.

A printable flyer with Customer Service Center contact information is available: https://dhhr.wv.gov/contacts/HN/Documents/Customer%20Services%202021.pdf
Managed Care Update: Carved Out Services

What benefits are NOT included in the managed care plans?

- Transplants
- Nursing facility services
- Medicaid waiver services*
  - Aged and Disabled
  - Intellectual/Developmental Disabilities
  - Traumatic Brain Injury
- Non-Emergency Medical Transportation (NEMT)**
- Personal Care Services
- Pharmacy
- Methadone Medication Assisted Treatment (MAT) Services

*CSEDW is a managed care benefit.

**NEMT services are managed and paid for by the broker, ModivCare.
Aetna Better Health of West Virginia (formerly CoventryCares)
Sarah White, Director of Network Management
Phone: 304-348-2089
Email: sewhite@aetna.com

Greg Carpenter, Chief Operating Officer
Phone: 304-348-2017
Email: carpenterg@aetna.com

The Health Plan
Christy Donohue, Vice President of MHT
Phone: 304-720-4923
Email: cdonohue@healthplan.org

UniCare Health Plan of West Virginia
Elizabeth Daniel, Provider Experience Manager Sr.
Phone: 304-410-9395
Email: elizabeth.daniel2@anthem.com

Misty Keglor, Manager, Provider Experience
Phone: 304-964-7580
Email: misty.keglor@anthem.com
In February 2020, the Medicaid and WVCHIP member online application portal, West Virginia inROADS, changed to the West Virginia People's Access to Help (WV PATH).

- WV PATH mirrors the capabilities of inROADS; however, it has a new look and feel for applying for benefits, reporting changes, and reviewing benefit information. Applicants, recipients, presumptive eligibility workers and community partners can access WV PATH at www.wvpath.org.

- All users will create a new username and password and will receive an email with instructions on how to create WV PATH credentials. For help using WV PATH, please call 1-844-451-3515.
WV PATH (Cont.)

Health Care
Health care programs for families and individuals with low income and limited resources including Medicaid, WV Children's Health Insurance Program (WCHIP), and Medicare Premium Assistance.

For more information, click the following...
- Health Care
- Family Assistance
- Food & Nutrition
Presumptive Eligibility

Since August 2015, certain West Virginia Medicaid enrolled providers have had the opportunity to determine presumptive eligibility:

- Hospitals
- Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)
- Comprehensive Community Behavioral Health Centers
- Free Clinics
- Local Health Departments (new effective June 1, 2020)

Interested entities must:

- Be a West Virginia Medicaid enrolled provider
- Submit a presumptive eligibility enrollment package to BMS
- Complete an online training course
- To begin enrollment or training, email DHHRBMSPresumptiveEligibility@wv.gov
- For more information: https://dhhr.wv.gov/bms/Provider/HBPE/Pages/default.aspx
Electronic Visit Verification (EVV) Updates

EVV Update:

▪ HHAeXchange was awarded the EVV contract and went live on March 1, 2021.

▪ All waiver and personal care agencies must enroll their direct care workers in order to receive payment for services rendered.

▪ HHAeXchange’s aggregator platform supports West Virginia’s Open/Hybrid EVV Model by consolidating all visit data regardless of the EVV system being used to enable the State to manage provider compliance and ensure participants are receiving the right care at the right time.

▪ West Virginia providers will be able to submit confirmed visits and bill directly to the State through the free HHAeXchange Portal.

▪ For more information: https://dhhr.wv.gov/bms/Programs/WaiverPrograms/EVV/Pages/default.aspx
Mountain Health Promise

- Mountain Health Promise is the name of the managed care program for children in foster care and post-adoptive children.
- Beginning March 1, 2020, Medicaid, residential, and socially necessary services for these children transitioned from FFS to statewide managed care services in order to create a care management portfolio for vulnerable youth populations.
- A single managed care organization, Aetna Better Health of West Virginia, was selected to oversee this population and coordinate health and social services.
Beginning March 1, 2020:

- CSEDW services are available for children who meet financial and medical eligibility and are enrolled in the waiver. Aetna Better Health of West Virginia coordinates health and social services.
- CSEDW services may be provided by employees of case management or waiver agencies, including but not limited to a licensed graduate social worker, licensed clinical social worker, licensed independent clinical social worker, licensed social worker, licensed professional counselor, registered nurse, direct-care worker and case manager.

Providers must be linked to an enrolled provider who is contracted with Aetna Better Health of West Virginia. Enrollment criteria include:

- National Provider Identifier
- Fingerprint background check
- Proof of completion of Bureau for Medical Services’ case management courses
As of October 2018, any prescription (new or refill) written by a provider who is not enrolled with West Virginia Medicaid will be denied.

Provider revalidation is required at least every three to five years for Medicaid providers under 2011 federal regulations for provider screening and enrollment.

- All providers (FFS and MCO providers) will need to revalidate.
- Revalidation is based on the enrollment effective date.
- Medicare Revalidation vs. Medicaid Revalidation.
  - Ownership and Provider Agreements

Enrollment with Medicaid and Medicare has been streamlined.

Newly opened provider types that can now enroll:

- Applied Behavior Analysis
- Case managers
- Direct care workers
Enrollment/Claim Alert

- Effective January 4, 2021, West Virginia Medicaid began actively denying coverage of any controlled substance prescription which has been written by a prescriber without a current or valid Drug Enforcement Administration number on file.
- Please verify your provider file is updated properly.
Enrollment checklists:

- Each provider type and specialty have criteria for enrollment, and a checklist for each will be posted on the portal.

**CRITERIA REQUIRED FOR ENROLLMENT**

**Physician**

Provider Name: _______________________                 NPI Number: ___________________________

**Required to Enroll in Medicare:** Yes; except L3 Neonatology and L8 Sports Medicine.

**Criteria for all specialties:**

- Current State License (per provider type)
- West Virginia Business License (If joining an established group, a business license is not required.)
Provider Enrollment Update (Cont.)
Providers are reminded to check all current and future employees, subcontractors, and agency staff for possible exclusion from participation in federal health programs. Failure to verify this information may result in recoupment of monies paid for services provided by an excluded individual or entity:

- List of Excluded Individuals/Entities (federal exclusion database) at https://exclusions.oig.hhs.gov/
- West Virginia Medicaid Provider Termination and Exclusion List (updated monthly) at https://www.wvmmis.com
  - Go to “Reference Material” -> “Medicaid Provider Sanctioned/Exclusion”
- It is a provider’s responsibility to ensure he/she does not bill or receive payment from West Virginia Medicaid or any other federal health care program for services rendered or ordered by an individual on the exclusions list(s).
Electronic Funds Transfer (EFT) Initiative

Initiative to reduce the number of paper checks due to cost and administrative burden:

▪ Providers are placed on **pay hold** if a bad EFT is returned until a corrected EFT is submitted.

▪ If you currently receive a paper check, please submit your EFT information immediately. Medicaid will stop sending paper checks in the future.

**Reminder:**

▪ New EFT forms are available on the West Virginia State Auditor’s website ([https://www.wvsao.gov/](https://www.wvsao.gov/)) to be completed with new provider enrollment and maintenance.
PERM Record Requests:

▪ The Centers for Medicare and Medicaid Services (CMS) conducts a medical record review of FFS payments to determine the appropriateness of the payment.

▪ Not every provider will be contacted to provide medical documentation; only those who provided services for the random sample of FFS claims will be selected. The random sample is pulled from all West Virginia Medicaid and WVCHIP FFS payments made in a fiscal year.

▪ Medical records are requested from the provider by the PERM Review Contractor for all FFS claims in the sample.

If there are issues with provider records, claims payments will be affected.
BMS is currently working with CMS and PERM contractors for Reporting Year (RY) 2023.

For the RY 2023 PERM cycle, PERM universes include claims and payments originally paid between July 1, 2021, and June 30, 2022.

Based on the current timeline, eligibility reviews began in January 2022, data processing begins in April 2022, and medical records in June 2022.
Federal regulations require state Medicaid agencies to establish a Recovery Audit Contractor (RAC) program as a measure to promote the integrity of the Medicaid program.

- Summer 2021, contract for RAC services was awarded to Health Management Systems, Inc. (HMS).
- The HMS RAC program will assist West Virginia Medicaid in identifying overpayments/underpayments and recovering overpayments made to Medicaid providers.
  - Overpayments can be result of provider billing or coding errors, failure to properly coordinate benefits, overuse of services, fraud, or abuse.
  - Recovery efforts targeted began January 2022.
  - HMS will correspond directly with providers.
  - Written notification from HMS should be reviewed and responded to promptly.
  - All written correspondence from HMS about a provider review will include a toll-free number that providers can utilize for review questions.
  - HMS will also manage the RAC appeal process.
The following must be identified with the modifier UD and billed at the Actual Acquisition Cost:

- Drugs used in out-patient surgery and infusion centers (sometimes referred to as mixed use drugs).
- Drugs administered in physician office settings.

The UD modifier identifies a drug obtained at a 340B price and ensures it will not be submitted to the manufacturer for rebate.

- The use of the UD modifier protects the 340B entity and the Medicaid program from rebate disputes regarding duplicate discounts.
- Entities are subject to audit by manufacturers or the federal government. Failure to comply with 340B requirements may make the 340B entity liable to manufacturers for refunds of discounts.
Policy Manual

Please be advised that the West Virginia Medicaid Provider Manual does not address all the complexities of Medicaid policy and procedures and must be supplemented with all Federal and State Laws and Regulations. Billing instructions can be found on the Molina Medicaid Solutions website at: http://www.wvmms.com.

Important Notice: Effective October 1, 2010, states were required by the Centers for Medicare and Medicaid Services (CMS) to incorporate all National Correct Coding Initiative (NCCI) methodologies into their systems for processing Medicaid claims. The following chapters of the BMS Provider Manual will be updated on an ongoing basis to reflect this requirement. Until all chapters are updated, this notice serves to inform providers that the required NCCI methodologies supersede any language in the BMS Provider Manual chapters as it relates to coding and/or the processing of claims submitted for services provided to WV Medicaid members.

For information on NCCI as it applies to Medicaid, click here.

COMBINED CHAPTER SEARCH - ALL CHAPTERS
All Chapters Chapters marked as new or updated below are not included in the All Chapters at this time.

INDIVIDUAL CHAPTER SEARCH - TABLE OF CONTENTS
Chapter 160 - General Information
Chapter 260 - Definitions and Acronyms Effective November 1, 2016
Chapter 360 - Provider Participation Requirements Effective May 19, 2018
Chapter 460 - Member Eligibility Effective December 1, 2015
Chapter 561 - Aged & Disabled Waiver Effective January 1, 2019
Chapter 562 - Reserved
Chapter 563 - Licensed Behavioral Health Centers Effective July 15, 2018
Chapter 564 - Substance Use Disorder Services Revised July 1, 2019
Chapter 565 - Dental, Orthodontics, and Oral Health Services Effective December 1, 2016

https://dhhr.wv.gov/bms/Pages/Manuals.aspx
Medicaid Rates

https://dhhr.wv.gov/bms/FEES/Pages/default.aspx

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<th>Clinical Diag. Lab Fees</th>
<th>DME Fees</th>
<th>Home Health Rates</th>
<th>Physicians (RBRVS) Fees</th>
<th>RBRVS Imaging Codes</th>
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**WV Medicaid Physician's Fee Schedules**

Acute Care Hospitals Inpatient Prospective Payment System (IPPS), also known as the DRG calculation's update!

The Office of Accountability and Management Reporting (OAMR), in its responsibility of Rate Setting and Provider Reimbursement for the Bureau for Medical Services (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 1, 2018, instead of five as in previous years. The July 1st base amount update will now coincide with the October 1st update of DRG weights. If you have any questions, please contact Leigh Ann Mears (OAMR) at 304-396-4819.

**Fee Schedule Updates**

The following fee schedules will now be effective April 1st through March 31st starting in calendar year (CY) 2018:

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

**Disclaimer**: Note that the absence or presence of a reimbursement code and its associated allowance on these pages does not guarantee Medicaid coverage of the item or procedure. Please refer to the appropriate West Virginia Medicaid provider manual for coverage determination.

- Ambulance Fee Schedule
- Ambulatory Surgical Center Rates
- Dental Fee Schedule
- DRG Weight Updates
- Drug Fee Schedules
- ER/EMR Fee Schedule
- Emergency Department Fee Schedule
- Inpatient Costs Rates
- Hospital OF Surgery Max Units
- Inpatient Fee Schedules
- Wagner Program Rates
- Aged and Disabled Waiver (ADW) Rates
- Children with Special Emotional Disorder Waiver (CEDW)
- Intellectual/Developmental Disability Waiver (IDDW)
- Traumatic Brain Injury Waiver (TBIW)
Policy 519.17, Telehealth Services (changes from passage of House Bill 2024):

Added originating sites:
- University-Based Health Centers
- A patient’s home
- Work location of a patient

Added distant site:
- Podiatrists
- Effective April 1, 2022, backdated to January 1, 2022, CMS added place of service 10 - telehealth provided in a patient’s home.
- Place of service 02 will be utilized for telehealth provided in place other than a patient’s home.
Interstate Telehealth practitioners:

- Interstate Telehealth Services allows the provision of telehealth services to a patient located in West Virginia by a health care practitioner located in another state.
- All Interstate Telehealth practitioners must be registered with the appropriate board on West Virginia.
- The Interstate Telehealth practitioner is subject to the laws and requirements set forth by the registering board. A practitioner currently licensed to practice in West Virginia is not subject to this registration.
Chiropractic Benefit

- Services are limited to a combined total of 20 visits per event of physical therapy, occupational therapy, osteopathic manipulation, Chronic Pain Management programs, and chiropractic treatment.
- All services beyond the initial 20 treatments require prior authorization.
- Chiropractors may submit claims using the appropriate basic and mid-level new patient evaluation and management (E&M) procedure codes.
West Virginia Medicaid has contracted with ModivCare to manage all non-ambulance NEMT.

- These requests may be made by members, their families, guardians or representatives and providers.
- Requests are to be made at least five business days before the NEMT service is needed.

The following is a list of West Virginia Medicaid covered non-ambulance transportation services:

- Specialized Multi-Passenger Van Transport (SMPVT)
- Common carrier/fixed route
- Individual transportation

**PHE Ambulance Update:**

- Ambulance contracts have been updated to allow transport to alternate sites including urgent care centers during the PHE.
FQHC/RHC: Dental Updates

- Form Locator 29: T1015 is required to be entered on line 1. Enter procedure code T1015, encounter code.
- Subsequent lines with specific American Dental Association (ADA) five-character codes starting with the letter D should be entered for all specific services rendered.
- Form Locator 31: Enter charges for each procedure code. ADA 5-character codes starting with the letter D must have a charge.
- ADA 2012 FQHCs and RHCs dental billing instructions can be found at [www.wvmmis.com/SitePages/Billing-Instructions.aspx](http://www.wvmmis.com/SitePages/Billing-Instructions.aspx).
Effective April 1, 2020, BMS reverted FQHC/RHC reimbursement back to the prior payment model when a third-party liability (TPL) is involved.

- When the Medicaid member has Medicare or private insurance (TPL), Medicaid is the secondary payer.
- BMS will pay only the coinsurance/deductible – NOT the full encounter rate.
Effective April 1, 2020, West Virginia Medicaid began following Medicare guidelines regarding the reimbursement of Modifier 51.

Modifier 51 multiple procedures:

- Use to indicate that multiple procedures (other than E&M) were performed at the same session by the same provider.
- Use Modifier 51 on the second and subsequent operative procedures when the procedures are ranked in relative value units (RVU) order.
- Do not use Modifier 51 on bilateral procedures or on add-on codes.
- Reimbursement:
  - First procedure = 100% of fee schedule.
  - Second procedure = 50% of fee schedule.
  - Third and subsequent procedures = 25% of fee schedule.
Effective April 1, 2020, West Virginia Medicaid began following Medicare guidelines regarding the reimbursement of Modifier 52.

Modifier 52 reduced services:

- Use to indicate that a service was partially reduced or eliminated at a physician’s discretion.
- Reimbursement: 50% of fee schedule.
- If the code description includes “unilateral or bilateral,” do not add Modifier 52.
- Do not use this modifier if an existing code properly identified the reduced service, such as an x-ray code describing a single view.
Effective April 1, 2020, West Virginia Medicaid began following Medicare guidelines regarding the reimbursement of the below modifier:

Modifier AD Medical Supervision by a physician:
- Use to indicate payment for services when the anesthesiologist is involved in furnishing more than four procedures concurrently.
- Reimbursement: 3 base units with no additional time units
- The units field must always be “1” when this modifier is submitted.
Professional and Facility Claims – Single Surgery:
- This includes CPT codes 58600, 58605, 58611, and 58615. All claims billed with these codes for single surgeries, including members that belong to an MCO, should be sent for processing to Gainwell Technologies for processing.

Professional Claims – Multiple Surgeries:
- If the member belongs to an MCO and the claim involves multiple CPTs, one of which is 58600, 58605, 58611, or 58615, a copy of the claim should be sent to the MCO and Gainwell Technologies.
- If the member belongs to FFS Medicaid and the claim involves multiple surgeries, one of which is 58600, 58605, 58611, or 58615, the claim should be sent to Gainwell Technologies only.

Facility Claims – Multiple Surgeries:
- If the member belongs to an MCO and the claim involves multiple surgeries, one of which is 58600, 58605, 58611, or 58615, the claim should be sent to the MCO only.
- If the member belongs to Medicaid FFS and the claim involves multiple surgeries, one of which is 58600, 58605, 58611, or 58615, the claim should be sent to Gainwell Technologies only.
Postpartum Eligibility

- Effective April 1, 2022, House Bill 2266 extends Medicaid coverage to pregnant women at or below 185% of the federal poverty level from two months to one-year postpartum.
- Effective April 1, 2022, WVCHIP has also extended postpartum care to one year.
Gender Edits

Effective January 1, 2021, West Virginia Medicaid will follow Medicare’s guidance for using modifier KX on CMS 1500 claims and Condition Code 45 on UB04s to identify services for members who do not identify with their assigned birth gender.

- For example, when a claim is received with a diagnosis of pregnancy and the MMIS system shows gender as “male,” the claim will automatically deny without a modifier.
- Since gender is fluid and can be different than what a person is assigned at birth, a modifier was added to identify and override the system up front.
- Gender edit overrides will be added to the routine audits completed by the BMS Office of Program Integrity (OPI).
Covered dental services for enrolled adults 21 years of age and older are divided into two levels of service:

1. Emergent procedures to treat fractures, reduce pain, or eliminate infection; and
2. Diagnostic, preventative, and restorative services.

- Beginning January 1, 2021, services classified as diagnostic, preventative, and restorative in nature require authorization prior to services being rendered and have a coverage limit of $1,000 per member per calendar year.
- Members are responsible for payment of service cost exceeding the $1,000 yearly limit.
- To view a list of covered services:
  
# Adult Dental Member Utilization

**As of January 1, 2022:**

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**Over 47,000 members, received over 309,000 services for over $25.8 million dollars in services ($24,777,546).**
To request a current procedural terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) code be added to your provider contract please contact your provider field representative.

Be prepared to provide a written request including:

- The code being requested
- Effective date requested
- Medical documentation showing necessity
- Reference material that shows the code is within the scope of licensure.

Only requests from enrolled providers will be considered.
There are two types of appeals for FFS:

- Service denials
  - Prior Authorization Contractor Reconsideration of Medical Necessity Determination - must be initiated within 60 days of PA denial.
  - DHHR Agency Fair Hearing Process - requested by the member for denied services not received.
- Document/Desk Review
  - Must be requested within 30 days after receipt of a notice of an adverse administrative action which affects his/her participation in the Medicaid program or reimbursement for a covered service.
  - Must be requested by a provider.

For full appeal details, see *Chapter 800A, General Administration* of the BMS Policy Manual, please visit: [https://dhhr.wv.gov/bms/Pages/Manuals.aspx](https://dhhr.wv.gov/bms/Pages/Manuals.aspx)

Billing agents working in conjunction with providers must follow the same time frames in requesting an appeal or desk/document reviews.
Website Resources

- Bureau for Medical Services: [http://www.dhhr.wv.gov/bms](http://www.dhhr.wv.gov/bms)
- Gainwell Technology (formerly Molina/DXC) – Medicaid FFS Fiscal Agent: [https://www.wvmmis.com/default.aspx](https://www.wvmmis.com/default.aspx)
- HMS – TPL Contractor: [http://www.wvrecovery.com](http://www.wvrecovery.com)
- Maximus – Managed Care Enrollment Broker: [https://www.mountainhealthtrust.com](https://www.mountainhealthtrust.com)
- Skygen - MCO Dental Benefits Manager: [www.sciondental.com](http://www.sciondental.com)
- ModivCare – NEMT Broker: [www.modivcare.com](http://www.modivcare.com)
Contacts

Sarah Young, Deputy Commissioner
Brandon Lewis, Medicaid Enterprise Systems Director
Diana Bossie, Interim MMIS Director
West Virginia Department of Health and Human Resources
Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, West Virginia 25301
304-558-1700
dhhr.wv.gov/bms
2022 Spring Provider Workshop

WV BMS, WVCHIP, Gainwell Technologies
Gainwell Technologies - Who Are We?

Gainwell is the leading provider of technology solutions that are vital to the administration and operations of health and human services programs.
### Bureau for Medical Services vs Gainwell Technologies

<table>
<thead>
<tr>
<th>Bureau for Medical Services</th>
<th>Gainwell Technologies</th>
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<tbody>
<tr>
<td>Administration of the States Medicaid Program</td>
<td>Fiscal Agent for BMS</td>
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<td>Policy Coordination</td>
<td>Claim Status</td>
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<td>Information Resource</td>
<td>Claims Processing</td>
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<tr>
<td>Rate Setting, Fee Schedules</td>
<td>Remittance Advice</td>
</tr>
<tr>
<td>Claims past timely filing deadline</td>
<td>Provider Enrollment</td>
</tr>
<tr>
<td>Performs Document Desk Reviews</td>
<td>Provider File Maintenance</td>
</tr>
</tbody>
</table>
Provider Enrollment: Top Submission Errors

Incorrect provider type/specialty selected

Not submitting credentials
- Board Certification/CV3
- ANCC
- License
- DEA

Incorrect office contact information
- Prevents outreach to notify of enrollment errors

Missing or incorrect documentation
- Signature pages
- Group Link (MPE-2)
- Practice Notification or Practice Agreement

Documentation not legible
- Please submit legible documentation with light shading
Electronic Visit Verification (EVV) Phase II:

In preparation for inclusion in the Electronic Visit Verification system, Home Health Attendants and Private Duty Nursing Attendants will be required to obtain an individual NPI and enroll with Gainwell Technologies.

Please be on the lookout for additional information as it becomes available.
Staff that provide PRSS services will be required to obtain a National Provider Identifier (NPI) number and be linked to your agency. The NPI number can be obtained by visiting the NPPES website: [nppes.cms.hhs.gov/#/](nppes.cms.hhs.gov/#/). The deadline for obtaining the NPI is 08/01/2022. Please note that if the worker has already applied and received an NPI number, they may use that number and do not need to apply for an additional number.

Once NPI numbers have been obtained for PRSS staff, behavioral health provider agencies will be required to link their staff’s NPIs to their agency on the WVMMIS Health PAS-OnLine web portal. Gainwell Technologies, Inc will be hosting webinars the month of July to assist with any questions related to the enrollment process. Additional guidance on this process will be coming soon.
Provider Enrollment

- Keep contact information such as phone, fax and address up to date
- Keep license/accreditation current upon renewal
  - Professional License
  - DEA
  - CLIA
  - JCAHO
- Keep certifications current upon renewal
Billing Updates

COVID-19 Self-Test Kit Coverage:

Effective January 26, 2022, WV Medicaid is providing coverage for the following four approved at-home COVID-19 self-test kits:

- BinaxNOW COVID-19 Antigen Self Test (NDC 11877001140)
- CareStart COVID-19 Antigen Home Test (NDC 50010022431)
- InteliSwab COVID-19 Rapid Test (NDC 08337000158)
- QuickVue At-Home COVID-19 Test (NDC 14613033972)

**Members paying for test kits out of pocket cannot be reimbursed.**

These tests require a prescription written by an enrolled WV Medicaid Prescriber or Provider type and MUST be billed through the pharmacy to be covered by Medicaid.
Billing Updates

Monoclonal Antibody Coverage:

Effective June 6, 2021, WV Medicaid will reimburse the administration of Covid-19 monoclonal antibody treatments, billed with M0243, M0245 and M0247 at the Medicare rate of $450.00.

Medication Assisted Treatment (MAT):

Effective July 1, 2021, HCPCS Code G2213, Initiation of medication to treat Opioid Use Disorder (OUD) in the emergency department setting, including assessment, referral to ongoing care, and arranging access to supportive services is covered when billed with a primary Current Procedural Terminology (CPT) Code of 99281, 99282, 99283, 99284, OR 99285.

Transthoracic Echocardiography Update:

Effective January 1, 2021 HCPCS Codes C8924 (Echo with contrast limited study) and C8929 (Echo with contrast full study) have been added to the Outpatient and Critical Access Hospital contracts.
Billing Updates

Type B Emergency Room Coverage

Effective January 1, 2021, WV Medicaid will reimburse following codes for Type B Emergency Rooms.

G0380  Level 1 hospital ER visit provided in a type B ER Dept
G0381  Level 2 hospital ER visit provided in a type B ER Dept
G0382  Level 3 hospital ER visit provided in a type B ER Dept
G0383  Level 4 hospital ER visit provided in a type B ER Dept
G0384  Level 5 hospital ER visit provided in a type B ER Dept

If your facility provides Type B emergency room services, please send a request in writing with a copy of your license to have the services added to your contract.
Billing Updates

Cancer Screenings Update:
Effective May 1, 2021, WV Medicaid now covers colorectal cancer screening tests for high-risk members and for members ages 45 and over. Previously, Medicaid covered members ages 50 and over. To view this policy change, please see Chapter 519.5, Cancer Screenings, Section 519.5.1 Colorectal Cancer Screenings.

Swing Bed Billing During COVID-19 Public Health Emergency:
WV Medicaid covers the use of swing beds in order to facilitate acute care hospital discharges and permit new admissions due to COVID-19 related increased need during the public health emergency declaration.
Effective September 21, 2020, the reimbursement of $238.00 per day per diem will be applied to all Acute Care Hospitals/Facilities.
Effective October 19, 2020, the individual Medicare Swing Bed rate will be reimbursed for each Critical Access Hospital/Facility.
All facilities should utilize Bill type 181X to identify the service of swing bed and use their current Acute Care or CAH NPI enrolled with Gainwell, not their Medicare swing bed NPI.
Billing Updates

American Rescue Plan Act (ARPA) of 2021

This act that was signed into law on March 11, 2021, increasing the federal match rate by 10% for the below programs will be ending on March 31, 2022. Please refer to the WV BMS website for specific rate information: American Rescue Plan Act (ARPA) of 2021 (wv.gov)

Licensed Behavioral Health Center (LBHC) Providers

Private Duty Nursing

Aged and Disabled Waiver (ADW) Agencies

Intellectual/Developmental Disability Waiver (IDDW) Agencies

Traumatic Brain Injury Waiver (TBIW) Agencies

Children with Serious Emotional Disorder Waiver (CSEDW) Agencies

Personal Care Service Providers
Ways to Submit Claims for Processing

Direct Data Entry: Via the WVMMIS Health PAS On-Line Portal
www.wvmmis.com

Electronic Submission: Vendor Specs are available at on the WVMMIS Health PAS On-Line Portal www.wvmmis.com/SitePages/Companion-Guides.aspx

Paper Submission: It is highly recommended that you only submit a paper claim when for special handling such as timely filing or appeals.
## Mail Paper Claims To:

<table>
<thead>
<tr>
<th>Claim Type</th>
<th>Address 1</th>
<th>City/StREET</th>
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<td>UB04 Claims</td>
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<td>PO Box 3766</td>
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<td>CMS-1500 Claims Reversal/Replacement Requests</td>
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<td>25327-3732</td>
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<tr>
<td>Hysterectomy/Sterilization/Pregnancy Termination</td>
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<td>Charleston, WV</td>
<td>25328-2254</td>
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Payment Processing Schedule

Monday
- Provider bills claims
- RAs and 835s are available on the web portal

Tuesday
- Provider bills claims
- EFT payment is deposited to provider’s bank account

Wednesday
- Provider bills claims
- Weekly claims submission cutoff at 6:00 p.m.

Thursday
- Provider bills claims

Friday
- Provider bills claims

*Holidays could affect the processing schedule
Claim Form Type

Professional (CMS-1500)
The following are examples of providers who would complete a CMS 1500 form:
- Physicians/Other practitioners
- Transportation providers
- Vision providers
- Supply providers
- HCBS/Waiver providers

Dental (ADA 2/12)
Only dental providers utilize this form

Institutional (UB-04)
The following are examples of providers who would complete a UB-04 form:
- Inpatient/Outpatient hospital
- Nursing facility
- Home health/PDN
- Hospice
- Dialysis center
- Residential treatment center
- Rural health clinics
Grievance and Appeal Submission Methods

Ways to submit an appeal:

• By online submission:

• By fax: Fax your appeal request to Gainwell Technologies at (304)348-3380.

• By mail: Mail your appeal request to below address:

  Gainwell Technologies
  Attn: Appeals Review
  PO Box 2002
  Charleston, WV 25327-2002

If submitting by mailing or fax, please include the Health PAS Grievance and Appeal Report cover page from the web portal or include a cover page with the below information.

Provider Name
National Provider Identifier (NPI)
Nature of Grievance/Appeal
Requested Action Contact Information: Contact Name, Telephone Number, Email
Timely Filing Policy

To meet timely filing requirements for WV Medicaid, claims must be received within one year from the date of service. The year is counted from the date of receipt to the “from date” on a CMS 1500, Dental or UB04. Claims that are over one year old must have been billed and received within the one-year filing limit. (See exceptions below for Medicare primary claims and backdated medical card.)

The original claim must have had the following valid information:

• Valid NPI number
• Valid member number
• Valid date of service
• Valid type of bill

Claims that are over one year old must be submitted with a copy of the remittance advice confirming that the claim was received prior to turning a year old. **Claims with dates of service over two years old are NOT eligible for reimbursement.**
Timely Filing Policy

This policy is applicable to reversal/replacement claims. If a reversal/replacement claim is submitted with a date of service that is over one year old, the replacement claim must be billed on paper with a copy of the original remittance advice. Additional services are not permitted to be billed on the replacement claim. If additional services are billed on the replacement claim that were not billed on the original claim and the dates of service are over one year old, the claim will be denied for timely filing.

Medicare Primary Claims/Secondary Claims

Timely filing requirement for Medicare primary claims is one year from the EOMB date.

Did you know that secondary claims can be submitted electronically? For more information, please call our EDI help desk at 888-483-0793, option 6.

TPL Primary Claims

Timely filing requirement for TPL insurance primary claims is one year from the date of service.
Timely Filing Policy

Backdated Medicaid Cards

If a member receives a backdated medical card and the provider wishes to accept it and bill Medicaid for services that occurred over a year ago, the claims must be billed within one year of the issuance of the card. Claims must be billed on paper with a copy of the medical card or letter of eligibility.

Medicaid Contracted MCOs and Timely Filing

Gainwell does not reimburse for any services the provider does not bill timely to the MCO. If the MCO denial is due to the member not being covered under the MCO and the provider determines that the member was covered with WV Medicaid at the time services were rendered, Gainwell may be responsible. In this case, Gainwell will accept MCO Medicaid remits as proof of timely filing as long as the date of the denial is not over a year from the date of service.

All timely filing claims should be mailed to the address below for consideration:
Gainwell Technologies
Attn: Timely Filing
PO Box 2002
Charleston, WV 25327-2002
Things to Remember

Claims submitted electronically must be entered by 6 p.m. on Wednesday

Claims webinars are conducted the third Wednesday of each month (unless otherwise noted)

Always check manuals, official notices, remittance advice banners and fee schedules for up-to-date information
Educational Webinars

Gainwell provides monthly webinars to expand training, provide updates, and support for the provider community.

Enrollment – 1st Wednesday of the month
Overview of how to start enrollment on the web portal.

Claims – 3rd Wednesday of the month
Overview of direct data entry of claims submission into the web portal.

Dates and times are posted on our Gainwell website [www.wvmmis.com](http://www.wvmmis.com)

Other training can be conducted upon request.
Chatbots for Call Centers

- Gainwell is finalizing the chatbot feature designed to answer FAQs on the portal.
- It can be used for both the Provider and Member portals.
- Questions can either be answered directly through the bot or with a link where the Provider/Member can do self-service within the portal.
# Call Center Support

**Support Hours:** Monday through Friday, 7am-7pm ET

<table>
<thead>
<tr>
<th>Department</th>
<th>Phone Number</th>
<th>Email</th>
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<tbody>
<tr>
<td>Provider Services</td>
<td>888-483-0793</td>
<td><a href="mailto:wvmmis@gainwelltechnologies.com">wvmmis@gainwelltechnologies.com</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="mailto:wvproviderfieldrepresentative@gainwelltechnologies.com">wvproviderfieldrepresentative@gainwelltechnologies.com</a></td>
</tr>
<tr>
<td>Long Term Care</td>
<td>888-483-0793x7</td>
<td><a href="mailto:LTC_v@gainwelltechnologies.com">LTC_v@gainwelltechnologies.com</a></td>
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<td>Provider Enrollment</td>
<td>888-483-0793x4</td>
<td><a href="mailto:wvproviderenrollment@gainwelltechnologies.com">wvproviderenrollment@gainwelltechnologies.com</a></td>
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<td>EDI Helpdesk</td>
<td>888-483-0793x6</td>
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<tr>
<td>Pharmacy Helpdesk</td>
<td>888-483-0801</td>
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<tr>
<td>Member Services</td>
<td>888-483-0797</td>
<td></td>
</tr>
<tr>
<td>CHIP</td>
<td>800-479-3310</td>
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</tr>
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</table>
Navigating the Portal

This website provides information to West Virginia Medicaid members, providers, trading partners and the public. Users may find helpful website links and documents within our public portal from the menu bar above. Providers and Members are encouraged to click on the appropriate tab above and log into our secure site for individual claims review, enrollment, reports and other helpful tools and information.
Navigating the Portal

- **Providers/Trading Partners**
  - View Medicaid eligibility and history
  - Submit claims
  - Check document status
  - Resume Provider Enrollment Application
  - Check Provider Enrollment Application Status
Navigating the Portal

• **Members**
  – Medicaid claims and notifications
  – Medicaid programs and benefits
  – Directory of Providers
Navigating the Portal

The File Exchange tab, provides an array of useful information such as X12 Responses, Reports, Alerts & Notifications, and Correspondence.
Navigating the Portal - Letters

Providers now can access letters on the WVMMIS Health PAS-OnLine web portal under Correspondence which expedites the notification time. Instead of waiting on a mailed document, the letters are automatically published to the portal for immediate retrieval.
Navigating the Portal – Reports

Another great feature is the Claims In Process that allows providers to check the status of a claim before it is finalized.
Region 1 Representative
Heather Rhodes hrhodes4@GainwellTechnologies.com

Region 2 Representative
Brandon Treola btreola@GainwellTechnologies.com

Region 3 Representatives
Katrena Edens kerdens@GainwellTechnologies.com
Michelle Ramsey rmiller222@GainwellTechnologies.com

Region 4 Representative
TBD  wvproviderfieldrepresentative@gainwelltechnologies.com

Region 5 Representatives
Whitney Choyce wchoyce@GainwellTechnologies.com
Stephanie Houghtaling shoughtaling@GainwellTechnologies.com
Evaluations

Your feedback is important to us!

Please take time to complete the evaluation that will be emailed to you.

Attendance certificate will be available to print.

Thank you for attending today!
SPRING 2022
PROVIDER WORKSHOP

Presented by Kepro
Existing Kepro Scope of Work

- Health Homes
- Aged and Disabled Waiver (ADW), Intellectual/Developmental Disabilities Waiver (IDDW), and Traumatic Brain Injury Waiver (TBIW) Services
- Personal Care Services
- Nursing Home PAS Review
- Behavioral Health Services
- Substance Use Disorder (SUD)

- School-Based Health Services
- Medical Services
- WVCHIP (Fee-For-Service)
- Socially Necessary Services
- Children with Serious Emotional Disturbance (CSEDW) Waiver Assessments
Websites/Direct Data Entry Portals

Medical Requests/WVCHIP Requests
• [https://portal.kepro.com](https://portal.kepro.com)

Health Homes
• [https://atrezzo.kepro.com](https://atrezzo.kepro.com)

Nursing Home PAS
• [https://portal.kepro.com](https://portal.kepro.com)

Behavioral Health/Socially Necessary
• [https://careconnectionwv.kepro.com](https://careconnectionwv.kepro.com)

Personal Care
• [https://wvltc.kepro.com](https://wvltc.kepro.com)

Aged & Disabled Waiver
• [https://wvltc.kepro.com](https://wvltc.kepro.com)

IDD Waiver
• [https://wvltc.kepro.com](https://wvltc.kepro.com)

TBI Waiver
• [https://portal.kepro.com](https://portal.kepro.com)
Members Served

- Fee-for-Service Medicaid and Behavioral Health Beneficiaries: 116,877 Currently Enrolled
- Aged & Disabled Waiver (ADW): 7,217 Active Members
- Personal Care: 5,786 Active Members
- IDD Waiver: 5,843 Active Members
- TBI Waiver: 88 Active members
- Health Homes: 9,412 Active Members
- NH PAS: Average review of 1,797 per month
Behavioral Health CareConnection® Tips

• Make sure you are using the appropriate Provider ID when making an authorization request.
  • Provider IDs are different for WV Medicaid Behavioral Health and WVCHIP.
  • Services available for prior authorization requests are tied to the Provider ID.
• The Member ID is a field that you define. It must be unique for each member, and up to eleven letters and/or numbers.
  • This number will follow that member for the lifetime your agency providers services to them.
  • If a member is discharged and then readmitted, you must use the same Member ID for that member.
• All diagnosis fields must be completed.
  • If the member has only one diagnosis, use code Z03.89 (no diagnosis) in the remaining fields.
  • Ensure the Disability Group chosen is consistent with the diagnosis entered for that member.
Behavioral Health CareConnection® Tips

- Authorization requests must be made within 10 days of service start date.
- “Agency Transaction ID” is assigned by the provider on the Service Request Page.
  - It is designed to allow you to track the service for a particular member.
- A “closure” is not a denial. This means there is a correction that needs to be made. The Care Manager will note why the request was closed.
  - Requests need to be resubmitted with corrections within 10 days of closure.
- Information submitted should reflect the member’s clinical condition over the 90 days prior to the “Request Date”.
- You may correct information on Kepro CareConnection® by clicking the paper icon under “Action” on your search request.
- Changes to Provider Medicaid ID, or Consumer Medicaid ID can be corrected by choosing the “Copy for Correction” (pencil icon).
• The Kepro CareConnection® user manual can be found at https://wvaso.kepro.com/wv-aso-behavioral-health.
• The Kepro CareConnection® web user guide provides steps that walk the user through only as much data as is required for your Agency type and the Service(s) being requested.
• Be sure to click “OK” on the “Disclaimer” web page or the record will not successfully submit.
• ALWAYS read the notes.
Behavioral Health Transition to Atrezzo

• Coming in 2022, Kepro Behavioral Health Services will be transitioning platforms from CareConnection® to Atrezzo Next Generation (ANG) for prior authorization submissions.
• Transition to ANG will have no affect on the policies or billing process.
• Communications regarding this transition will be sent out via email and posted on the Kepro website: https://wvaso.kepro.com/.
• Please be sure that you have complete the contact update to receive the most up-to-date information regarding this transition at https://survey.alchemer.com/s3/6754966/Kepro-Behavioral-Health-Contact-Information-Update.
Medical Services Transition to Atrezzo

• February 1, 2022, Kepro transitioned platforms from WV C3 Provider Portal to Atrezzo Next Generation (ANG) for WV Medicaid fee-for-service Medical prior authorization submissions.
• The transition to ANG does not affect the policies set in place by the Bureau for Medical Services or the current billing processes for Gainwell Technologies.
• Kepro conducted 26 trainings in total on the registration process and how to submit prior authorizations using ANG.
• Instructional videos and training documents are located at https://wvaso.kepro.com/wv-aso-medical-services.
• ANG took place of Kepro’s C3 Direct-Data-Entry Provider Portal.
  • C3 provider portal was utilized by WV Medicaid fee-for-service providers to submit prior authorizations online, prior to February 1, 2022.
  • Any services that were in C3 are available in ANG.
• ANG is most compatible with Google Chrome.
• DO NOT USE INTERNET EXPLORER.
• The website for registration and submission is https://portal.kepro.com.
  • Provider registration codes are either the NPI or WV Medicaid Provider ID.
• Registration is required to use ANG.
  • If you have an active ANG web account, you will not need to register again.
Atrezzo Next Generation – Things to Know

- The first person to register their National Provider Identifier (NPI) number is automatically the Group Administrator and responsible for adding other users.
- Cases that were submitted in the C3 Provider Portal were migrated to ANG.
- Faxing is an option; however, provider portal usage is strongly encouraged.
- There are no changes to timeframes and turnaround times.
- Required documentation for review has not changed.
- The Master Code List (MCL) is available for provider use and is located at https://wvaso.kepro.com.
- For questions and technical assistance, please call 800-346-8272 or email wvmedicalservices@kepro.com.
Benefits of Utilizing Atrezzo Next Generation

- Online submissions auto-validate and all mandatory fields must be completed to submit.
  - Providers will be notified of incomplete fields prior to submission.
- Documentation can be uploaded by the provider to ANG.
- ANG has an integrated communication system that allows for direct messaging between Kepro staff and providers.
  - Please note: Do not include personal health information (PHI) in the direct messaging system.
  - Direct messaging capabilities are not available if submitted via fax.
- Change of status emails are sent to the submitting user.
  - These email capabilities are not available if submitted via fax.
- There is no wait time for customer service staff to key your request.
Adult Dental Services

- Providers can submit prior authorizations online or by fax.
- Fee-for-Service adult dental services that require prior authorization must be submitted to Kepro. Any services provided in an operating room must be submitted as an Outpatient Surgical request on ANG.
- Authorizations will be issued with a 180-day date span.
- If there is prior approval from another provider, the second provider will need to submit a “vendor/provider” letter signed electronically or cosigned if obtained verbally from the member indicating the change.
- The cost of dental services reimbursed is determined by the fee schedule.
  - Dental fee schedule for 2022 is available at [https://dhhr.wv.gov/bms/fees/pages/default.aspx](https://dhhr.wv.gov/bms/fees/pages/default.aspx)
  - Federally Qualified Health Centers (FQHCs) receive their encounter rate for dental services. The encounter rate is the amount that counts towards the member’s $1,000 limit.
Adult Dental Services

- The $1,000 service limitation does not start over or reset when a member changes from fee-for-service to a managed care organization (MCO) or from MCO to fee-for-service.
  - Any service provided during MCO enrollment will be subtracted from the $1,000 and will be recognized by Kepro.
- Cases submitted after the $1,000 has been exhausted will be closed. The provider is to make arrangements with the member.
- Adult dental benefits are a calendar year benefit.
  - A calendar year starts January 1st and ends December 31st.
  - Members that have a balance remaining from their $1,000 allowable amount will not be carried over to the new year.
  - Adult dental prior authorizations will not be carried over to the new year. A new prior authorization will need to be submitted if services were not performed before the end of the calendar year.
Tips for Successful Medical Authorizations

- Check diagnosis codes before submission.
  - Authorization numbers for cases that contain non-billable/non-specific diagnosis codes will not export to the claim's vendor.
- All unlisted service codes require prior authorization.
- Check the Master Code List (MCL) before submitting via direct data entry (DDE) or by fax.
  - The MCL can be found at https://wvaso.kepro.com.
- Remember to attach or fax documentation that justifies medical necessity.
  - This can include written or electronic orders, certificates of medical necessity, or x-rays if applicable.
- Dental x-rays and attachments must contain the member’s name.
Kepro Contact Information

Behavioral Health
• Local Line: 304.346.6732
• Toll Free: 800.378.0284
• Fax: 866.473.2354

Aged & Disabled Waiver
• Toll Free: 844.723.7811
• Fax: 866.212.5053
• General Email: WVADWaiver@kepro.com
• Email to submit documentation: ADWdocumentation@kepro.com

TBI Waiver
• Toll Free: 866.385.8920
• Fax: 866.607.9903
• General Email: WVTBIWaiver@kepro.com

CSED Waiver
• Toll Free: 844-304-7107
• Fax: 866.473.2354
• General Email: wvcسدw@kepro.com

I/DD Waiver
• Local Line: 304.380.0617
• Toll Free: 866.385.8920
• Fax: 866.521.6882
• General Email: WVIDDWaiver@kepro.com
Kepro Contact Information

Personal Care
• Toll Free: 844.723.7811
• Fax: 866.212.5053
• General Email: WVPersonalCare@kepro.com

FQHC
• Toll Free: 888.571.0262
• Fax: 866.438.1360

Social Necessity
• Local Line: 304.380.0616
• Toll Free: 800.461.9371
• Fax: 866.473.2354

Medical
• Toll Free: 800.346.8272
• General Email: wvmedicalservices@kepro.com

Nursing Home PAS
• Toll Free: 844.723.7811
• Fax: 844.633.8425
• General Email: WVPAS@kepro.com
Medical Fax Numbers

Bariatric/Inpatient/Inpatient Rehab Under 21/Organ Transplants
  • 844.633.8426
Outpatient Surgery
  • 844.633.8427
Imaging/Radiology/Lab
  • 844.633.8428
Cardiac & Pulmonary Rehab/DME/Orthotics & Prosthetics
  • 844.633.8429

Home Health/Hospice/Private Duty Nursing
  • 844.633.8430
Audiology/Speech/Chiropractic/Dental/Orthodontic/Podiatry/PT/OT/Vision
  • 844.633.8431
Modification Requests/EPSDT/Out of Network
  • 866.209.9632
<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Email</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emily Proctor</td>
<td>Medical/IDDW/BH/SUD Waiver Director</td>
<td><a href="mailto:EBProctor@kepro.com">EBProctor@kepro.com</a></td>
<td>304-935-5713</td>
</tr>
<tr>
<td>Karen Wilkinson</td>
<td>UM Nurse Manager</td>
<td><a href="mailto:Karen.Wilkinson@kepro.com">Karen.Wilkinson@kepro.com</a></td>
<td>304-996-7020</td>
</tr>
<tr>
<td>Alicia Perry</td>
<td>WV Medical Program Specialist</td>
<td><a href="mailto:APerry@kepro.com">APerry@kepro.com</a></td>
<td>EXT. 4452</td>
</tr>
<tr>
<td>Sierra Hall</td>
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</tr>
<tr>
<td>Jami Plantin</td>
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</tr>
<tr>
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<tr>
<td>Lauren Payne</td>
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<td>EXT. 4408</td>
</tr>
</tbody>
</table>

General Kepro and WVCHIP Information: [https://wvaso.kepro.com](https://wvaso.kepro.com)
Authorization Submissions: [https://portal.kepro.com](https://portal.kepro.com)
Spring 2022 West Virginia Provider Workshops

HHAeXchange Update

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Agenda

- EVV Overview
- Provider EVV Compliance Reporting
- Billing through HHAeXchange
- Upcoming Webinars & Provider Resources
EVV Overview
The 21st Century CURES Act requires that the following data elements be captured and verified through Electronic Visit Verification:

- Type of Service Performed
- Individual Receiving the Service
- Date of the Service
- Location of the Service Delivery
- Individual Providing the Service
- Time the Service Begins and Ends
What Providers Need to Know

➢ Cures Act Mandate in effect as of January 1st, 2021

➢ West Virginia providers have had access to HHAeXchange since March 1st, 2021
  - Once Caregivers are enrolled with Gainwell, each provider is expected to begin confirming visits using EVV
  - Agencies performing only Service Coordination are not required to do EVV at this time

➢ HHAeXchange is the State Fee-for-Service EVV and Aggregation Vendor
What Providers Need to Know

➢ The state has provided a free EVV solution through HHAeXchange and collect all visit data, regardless of the EVV system being used.

➢ If your agency uses another EVV vendor, that is great! However, you are still required to send all visit data for services in scope to HHAeXchange for aggregation purposes.

➢ Need to set up an EDI connection to send your data? Contact edisupport@hhaexchange.com.
Provider EVV Compliance Reporting
How Can I Find My Compliance Percentage?

- Within the HHAeXchange portal there are a series of EVV reports available, which can be accessed at any time to check your agency’s compliance with the Cures Act.
Recommended Approach to Increasing Compliance

➢ The “Exception by Caregiver” report allows you to view each Caregiver’s exception rate.

➢ Reviewing this report to find caregivers with high exceptions helps you to target specific folks who may need additional training or assistance with understanding EVV.
Exception by Caregiver Report
Billing through HHAeXchange
West Virginia Billing Go-Live

- HHAeXchange EVV go-live was March 1, 2021

- As part of EVV compliance, CMS requires proof of visit via electronic means prior to payment
- Billing Go-Live: **October 1, 2021**

- Billing through HHAeXchange ensures each claim submitted is backed up with visit evidence for services requiring EVV
  - Visits confirmed manually can also be billed, as long as there is still electronically recorded proof that the visit occurred
General Billing Updates

➢ Over half of eligible agencies have successfully billed through HHAeXchange since October 1, 2021

➢ It is recommended that agencies who have not attempted billing through HHAeXchange start the process
Benefits of Billing through HHAeXchange

➢ Agencies can choose the visits to invoice

➢ Pre-billing and Billing Review in HHAeXchange scrubs visits to ensure they have all necessary elements and follow standard billing rules to reduce issues post-submission

➢ Reporting is available in each provider portal to track billed visits through HHAeXchange

➢ Ensures all visits are compliant with the Cures Act prior to being paid
Upcoming Webinars & Provider Resources
Upcoming Webinars

➢ HHAeXchange hosts weekly lunch-and-learn’s covering various topics:
  ➢ Administrative functions
  ➢ Resolving Pre-billing Errors
  ➢ Managing Billing Review
  ➢ Effective Use of the Communication Module
  ➢ EVV Call Dashboard – Managing Exceptions
  ➢ And many more!

➢ Visit this link for more information about webinars:
  https://hhaexchange.com/portal-webinars/
Provider Resources

- Provider Support Center:
  - Upper right-hand corner of the provider portal, click “Support Center”

- Provider Information Center: https://hhaexchange.com/wv/
  - Full FAQ, including Billing specific questions, found here
Key Contact Information

- HHAeXchange Support
  - Phone: 866-983-4627
  - E-mail: wvsupport@hhaexchange.com
TIME FOR A BREAK
We will be right back!
Overview

What is Mountain Health Trust?

Managed Care

Member Enrollment

Provider File

Outreach and Education
As of March 2022, there are approximately 630,801 WV residents covered by Medicaid and WV CHIP.
## Managed Care Terminology

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fee For Service</td>
<td>Members who are <strong>exempt</strong> from managed care are served through a Fee-for-Service delivery system administered by Gainwell Technologies.</td>
</tr>
<tr>
<td>Managed Care</td>
<td>Members who are <strong>eligible</strong> for managed care are served through the Mountain Health Trust or WVCHIP programs.</td>
</tr>
<tr>
<td>Enrollment Broker</td>
<td>MAXIMUS coordinates and enrolls all eligible managed care members into a managed care organization (MCO).</td>
</tr>
<tr>
<td>Managed Care Organization</td>
<td>An MCO is often referred to as a health plan that coordinates the provision of health services through networks and case management.</td>
</tr>
</tbody>
</table>
What is Mountain Health Trust

Mountain Health Trust is the managed care program for West Virginia. With Mountain Health Trust, a member may choose a:

- Managed care organization (MCO)
- Primary care provider (PCP)

In addition, Mountain Health Trust is **not**:

- an MCO/Health Plan.
- able to verify Medicaid eligibility.
- able to make exemptions for members.
- able to credential providers.
The Mountain Health Trust is the health services provided to Medicaid members.

West Virginia Children’s Health Insurance Program is the health services provided to WVCHIP members.
Managed Care Eligibility

Medicaid Managed Care Members should provide both their State Medicaid Card and their MCO health plan membership card when receiving healthcare services.

WVCHIP members should provide their MCO health plan membership card when receiving services.

Providers may verify eligibility and enrollment for Fee-For-Service and MCO members via the Gainwell Provider Portal.
Members who are exempt from managed care and are Medicaid Fee-for-Service (Traditional Medicaid) should provide their State Medicaid Card when receiving healthcare services.

Providers may verify Medicaid eligibility and enrollment for Fee-For-Service and MCO members via the Gainwell Provider Portal.
Once DHHR determines eligibility, Members are transferred to Gainwell Technologies.

Gainwell Technologies transfers eligible managed care members to MAXIMUS.

Members must contact MAXIMUS to enroll in an MCO of their choice.

MAXIMUS enrolls members into an MCO.

MAXIMUS mails enrollment packets to all newly eligible managed care members.

MCOs will provide members with their member identification card.
Members must enroll prior to the cutoff date in order to have an effective enrollment date on the 1st day of the next month. Also, when a member enrolls into an MCO, they will need to choose a Primary Care Provider. If the individual does not select a PCP, the MCO will assign them one.
Eligible members have 30 days to enroll into an MCO of their choice or they will be Auto-assigned to an MCO.

30 Days to make a Choice

A member enrolls into an MCO of their choice before cutoff date.

Member MCO Choice

Cut-off Date for the Month

Cut-off Date

Member’s effective coverage date will be the 1st day of the next month.

Effective Coverage Date
Eligible members have 30 days to enroll into an MCO of their choice or they will be Auto-assigned to an MCO.

**Cut-off Date**

A member enrolls into an MCO of their choice *after* cutoff date.

**Effective Coverage Date**

Member’s effective coverage date will be the 1st day of the month after next.

**30 Days to make a Choice**

**Cut-off Date for the Month**

**Member MCO Choice**
Call us at 1-800-449-8466. We are here Monday through Friday from 8:00 a.m. - 6:00 p.m. For hearing impaired (TTY), please call 1-304-344-0015.

Visit our website to find answers to your questions, compare health plan options, search for providers, or enroll in a health plan at mountainhealthtrust.com.

You can mail your completed enrollment form to us at: West Virginia Mountain Health Trust, 231 Capitol Street, Suite 310, Charleston, WV 25301.
MAXIMUS receives a weekly provider file from each MCO that contains all providers currently in their health plan network. The provider file contains: provider name, address, phone number, group or clinic name, provider type, and specialty. The provider file received from each MCO is compiled into a master file that is used on the www.mountainhealthtrust.com website and by our call center agents to validate provider information. If there is an error in your provider information, you may contact our call center at 1-800-449-8466 and we will forward the correction to the appropriate MCO.
Outreach and Education

Region I – Steve Richardson, OES
StevenPRichardson@Maximus.com
304-844-6148

Region II – Spring Blankenship, OES
MelodieSpringBlankenship@Maximus.com
304-545-6773

Region III – Bonnie Harrell, OES
BonnieHarrell@Maximus.com
304-663-1642
Aetna Better Health® of West Virginia

Provider Relations
Service Area Map

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Kayla Bess
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BessK1@aetna.com

Lisa Sentich
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SentichL@aetna.com

Richard Day
304-348-2931
DayR1@aetna.com

Aimee Davis
304-348-2011
DavisA2@aetna.com

Layla Sawyers
304-348-2013
SawyersL@aetna.com

Outside West Virginia will be handled by the representative based on the West Virginia border counties.

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Mountain Health Promise

- ABH of WV currently has 27,917 members enrolled in the Mountain Health Promise program

- Cross Functional teams at the health plan work with providers to improve outcomes and support our members and their families.

- We have seen a significant decrease in members being placed at residential facilities out of state from 6.36% in January 2021 to 5.58% in December 2021
Children with Serious Emotional Disorder Waiver

- ABH of WV currently has 398 members enrolled under the waiver

- We are working to expand the provider network for these services. If you are interested in becoming a CSED Waiver provider, please reach out to your Provider Relations Representative.
WV CHIP

- ABH of WV currently has 5,631 members enrolled in the WV CHIP program

- Members in the WV CHIP program with ABH of WV have access to value added benefits such as Camp Scholarships and gift cards for participation in wellness programs.
Provider Portal Updates

• All features are open in Availity as of 2/1/22

• Current features include:
  ✓ Prior authorization submission and status viewing
  ✓ Appeal submission
  ✓ Eligibility and benefits
  ✓ Claim status
  ✓ Panel Roster
  ✓ Reconsideration Submission

• Enhancements scheduled for 2022
  ✓ Remittance viewer

• Register for access at https://availity.com/provider-portal-registration
Network practitioners and providers are subject to Aetna Better Health’s documentation requirements for EPSDT Services and the following additional documentation requirements:

- The medical record shall include the age-appropriate screening provided in accordance with the periodicity schedule.
- Documentation of a comprehensive screening shall at a minimum, contain a description of the components described below. We recommend that practitioners and providers send reminders to parent when screenings, immunizations, and follow-up services are due.
- Use of the HealthCheck screening questions and/or protocols.
EPSDT Continued

- Increased reimbursement for two CPTs effective 1/1/22
  - 96110 with EP modifier $8.86
  - 96127 with EP modifier $4.85
Claims Address Update

• Effective 2/14/22 mailed claims should be sent to:

  Aetna Better Health of WV
  PO Box 982965
  El Paso, TX 79998-2965

• Mail will be forwarded for 12 months

• Begin using this address now to avoid processing delays
Grievance & Appeals Address Update

- Effective 7/1/21 mailed grievances and appeals should be sent to:

  Aetna Better Health of WV
  Attn: Appeal Coordinator
  PO Box 81040
  5801 Postal Rd
  Cleveland, OH 44181
Prior Authorization Changes

• Effective 11/1/21 prescribing practitioner name, NPI, phone number and fax number are required before prior authorization requests will be reviewed

• Effective 12/1/21 the below codes require Prior Authorization:
  
  • 0018M, 0255U – 0284U, A4453, C1831, C9081 – C9084, C9779, J0699, J0741, J1305, J1426, J1445, J1448, J2406, J9247, J9318, J9319, K1021 – K1027, P9026, Q2054, Q4251 – Q4253, Q9004, S9432, C9780
OB Ultrasound Update

Effective 5/1/22

• CPT 76801, 76802, 76805, 76810, 76813 & 76814 limited to 1 per routine pregnancy unless records are submitted documenting medical necessity for additional ultrasounds

• CPT 76811, 76812, 76817, 76818, 76819, 76820, 76821, 76825, 76826, 76827 & 76828 are only payable for high-risk pregnancy diagnosis codes
OB Ultrasound Update Continued

- CPT 76815 is limited to 1 per routine pregnancy, or 2 per high-risk pregnancy
- CPT 76816 is limited to 1 per routine pregnancy or 5 per high-risk pregnancy
Social Determinants of Health (SDoH) Update

• Social Determinants of Health data is important to Aetna Better Health of West Virginia as it enables us to better identify members who may benefit from outreach from a care manager.

• Providers are encouraged to add SDoH ICD-10 “Z” codes to their claims when billing so that we can gather this pertinent information.
Chiropractic Update

• Prior authorization is required after the first 20 visits in a calendar year.

• The 20 visit maximum applies to any combination of these services:
  ✓ Physical Therapy
  ✓ Occupational Therapy
  ✓ Osteopathic Manipulation
  ✓ Chronic Pain Management Program
  ✓ Chiropractic Services

• Effective 3/1/22 prior authorization may be requested for these services even if our system does not show that the member has used their 20 visit maximum yet.
ABH of WV Provider Workshops

We are resuming our in-person Provider Workshops for Summer 2022. Look for a fax/email blast to come out in May for your RSVP or let your Provider Relations Representative know that you want to attend.

- July 20th – Valley Park Conference Center, Hurricane, WV
- July 25th – Hilton Garden Inn, Martinsburg, WV
- July 26th – Holiday Inn University Area, Morgantown, WV
- July 27th – Tamarack, Beckley, WV
Provider Webinars

• New Provider Orientation Webinar – the fourth Thursday of every month at 11:00 am.

• Quarterly Existing Provider Education/Updates Webinars – September 30th and December 30th at 2:00 pm.

• RSVP to your Provider Relations Representative.
Thank you!
Company Overview – Who We Are

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740.699.6248

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Marsha Shahrokh
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OPEN

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304.285.6513

Marjorie Burdick
mbyrnick@healthplan.org
304.285.6507

Open

Nicole Morehouse
nmorehouse@healthplan.org
304.220.6392
Palladian Health is Now eviCore

Authorization for the following services (previously provided by Palladian Health) are now provided by eviCore healthcare (eviCore) for dates of service (DOS) beginning January 1, 2022:

Musculoskeletal (MSK)
• Specialized Outpatient Therapies
  • Physical Therapy (PT) and Occupational Therapy (OT)
• Chiropractic Care
• Pain Management
• eviCore is now reviewing joint and spine surgery for medical necessity and authorization for date of service (DOS) beginning January 1, 2022

• Services performed without authorization may be denied for payment and providers may not seek reimbursement from members

• Questions may be directed to eviCore by phone 1.800.918.8924 or email support@evicore.com
eviCore PAC DME Code Changes

eviCore is including two new Healthcare Common Procedure Coding System (HCPCS) codes and terming one for use in the Durable Medical Equipment (DME) post-acute care (PAC) program, effective March 1, 2022.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
<th>Prior Approval (Y)/Non-Prior Approval (N)</th>
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<tbody>
<tr>
<td>A4436</td>
<td>Irrigation supply; sleeve, reusable, per month</td>
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<tr>
<td>A4437</td>
<td>Irrigation supply; sleeve, disposable, per month</td>
<td>N</td>
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<tr>
<td>A4397</td>
<td>Irrigation supply; sleeve, each</td>
<td>TERM</td>
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</tbody>
</table>
Effective June 1, 2022, eviCore is changing the following (18) DME HCPCS codes from no prior authorization required to prior authorization required:

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4230</td>
<td>Infusion set for external insulin pump, non needle cannula type</td>
</tr>
<tr>
<td>A4232</td>
<td>Syringe with needle for external insulin pump, sterile, 3 cc</td>
</tr>
<tr>
<td>A4351</td>
<td>Intermittent urinary catheter; straight tip, with or without coating (teflon, silicone, silicone elastomer, or hydrophilic, etc.), each</td>
</tr>
<tr>
<td>A4352</td>
<td>Intermittent urinary catheter; coude (curved) tip, with or without coating (teflon, silicone, silicone elastomeric, or hydrophilic, etc.), each</td>
</tr>
<tr>
<td>A4353</td>
<td>Intermittent urinary catheter, with insertion supplies</td>
</tr>
<tr>
<td>A4409</td>
<td>Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, without built-in convexity, 4 x 4 inches or smaller, each</td>
</tr>
<tr>
<td>A4520</td>
<td>Incontinence garment, any type, (e.g., brief, diaper), each</td>
</tr>
<tr>
<td>A4554</td>
<td>Disposable underpads, all sizes</td>
</tr>
<tr>
<td>HCPCS Code</td>
<td>Description</td>
</tr>
<tr>
<td>------------</td>
<td>-------------</td>
</tr>
<tr>
<td>A6197</td>
<td>Alginate or other fiber gelling dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., each dressing</td>
</tr>
<tr>
<td>A9274</td>
<td>External ambulatory insulin delivery system, disposable, each, includes all supplies and accessories</td>
</tr>
<tr>
<td>A9275</td>
<td>Home glucose disposable monitor, includes test strips</td>
</tr>
<tr>
<td>A9276</td>
<td>Sensor; invasive (e.g., subcutaneous), disposable, for use with interstitial continuous glucose monitoring system, one unit = 1 day supply</td>
</tr>
<tr>
<td>A9277</td>
<td>Transmitter; external, for use with interstitial continuous glucose monitoring system</td>
</tr>
<tr>
<td>A9278</td>
<td>Receiver (monitor); external, for use with interstitial continuous glucose monitoring system</td>
</tr>
<tr>
<td>E0570</td>
<td>Nebulizer, with compressor</td>
</tr>
<tr>
<td>E0607</td>
<td>Home blood glucose monitor</td>
</tr>
<tr>
<td>K0553</td>
<td>Supply allowance for therapeutic continuous glucose monitor (cgm), includes all supplies and accessories, 1 month supply = 1 unit of service</td>
</tr>
<tr>
<td>K0554</td>
<td>Receiver (monitor), dedicated, for use with therapeutic glucose continuous monitor system</td>
</tr>
</tbody>
</table>
WV Children’s Health Insurance Program (WVCHIP)

• Effective July 1, 2022, WVCHIP will transition its pharmacy benefit manager (PBM) from CVS to Express Scripts

• All members will receive new cards with this updated information prior to July 1

• WVCHIP members may now access substance use disorder (SUD) residential treatment services (CPT codes H2036 U1, U3, U5 and U7)

• Claims will reimburse at the WV Medicaid fee schedule for these services

• Behavioral health providers are reminded that individual practitioners are required to credential with The Health Plan (THP) prior to rendering any services
**EPSDT Enhanced Rates**

- Effective January 1, 2022, CPT codes 96110 (developmental and behavioral screening and testing) and 96127 (brief emotional/behavioral assessment) will reimburse at an enhanced rate when billed for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services.

- These CPT codes must be billed with an EP modifier to receive the enhanced rate.

- The EP modifier allows THP to confirm that all elements of the EPSDT screener were completed for the member.

- Providers should use either the EPSDT forms available via the WV Bureau for Public Health HealthCheck Program's website for documenting screening results or an electronic health record inclusive of the same data points.

- Forms may be accessed at: [https://dhhr.wv.gov/HealthCheck/providerinfo/Pages/default.aspx](https://dhhr.wv.gov/HealthCheck/providerinfo/Pages/default.aspx)
Lead Screening Exams

• THP, in partnership with the West Virginia Department of Health and Human Resources (WV DHHR), is recommending that providers complete a lead screening exam as part of any upcoming well-child visit

• Providers are advised to bill CPT code 83655 for this service

• Educational materials are available to provider offices upon request

• Please contact your assigned Practice Management Consultant (PMC) to request educational materials
Effective July 1, 2021, THP implemented a Social Determinants of Health (SDOH) incentive program to reimburse providers for billing select Z diagnosis codes in conjunction with Evaluation and Management (E/M) codes. This program remains in place.

The SDOH program allows our care managers to learn more about the social needs of our members and refer them to appropriate social services.

The below codes, when billed with an E/M code qualify for an enhanced payment:

<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z55</td>
<td>Problems related to education and literacy</td>
</tr>
<tr>
<td>Z56</td>
<td>Problems related to employment and unemployment</td>
</tr>
<tr>
<td>Z57</td>
<td>Occupational exposure to risk factors</td>
</tr>
<tr>
<td>Z59</td>
<td>Problems related to housing and economic circumstances</td>
</tr>
<tr>
<td>Z60</td>
<td>Problems related to social environment</td>
</tr>
<tr>
<td>Z62</td>
<td>Problems related to upbringing</td>
</tr>
<tr>
<td>Z63</td>
<td>Other problems related to primary support group, including family circumstances</td>
</tr>
<tr>
<td>Z64</td>
<td>Problems related to certain psychosocial circumstances</td>
</tr>
<tr>
<td>Z65</td>
<td>Problems related to other psychosocial circumstances</td>
</tr>
</tbody>
</table>
Screening Breathalyzer Reimbursement

Effective January 1, 2022, THP will reimburse screening breathalyzers only when the test is medically necessary

Breathalyzer claims are medically necessary under the following circumstances:

1. No other test ordered on the day of the visit could screen for alcohol use in the panel; and

2. The member has a history of:
   a. Alcohol use disorder or
   b. DUI in the past five years or
   c. Has the appearance of being intoxicated on the DOS or
   d. Smells of alcohol on the DOS
Drug Screening in SUD Population

Drug Screening in Outpatient SUD Populations

• THP has approved Point of Care testing with oral fluids billed as CPT code 80305 (drug test(s), presumptive, any number of drug classes)

• THP does not recommend routine confirmatory testing and doing so may be viewed as overbilling

• THP prefers random unannounced drug tests to scheduled drug tests
Medication Disposal

• THP has partnered with DisposeRx to provide a tool to safely and securely dispose of expired or terminated medications

• DisposeRx contains a powder that is non-toxic and non-hazardous

• The technology includes crosslinking polymers that activate in water in less than 30 seconds when combined with medication in the original prescription container

• THP is providing DisposeRx packets free of charge to providers, so you may provide them to members discharging from SUD residential and other behavioral health programs

• THP is interested in identifying members who are discharging to a location that is not managed and may contain outdated medications of family members or friends

• Contact your PMC if you would like to receive this product
OBMAT Pregnancy Testing

• Participation in an Office-Based Medication Assisted Treatment (OBMAT) Program is not justification for frequent pregnancy testing on members of THP

• THP defines frequent pregnancy testing as more than once per month

• A provider should judge for themself their degree of comfort with treatment agents containing both Naloxone and Buprenorphine and test, accordingly, documenting the need for such testing
Peer Recovery Support Services

• Beginning October 1, 2022, the Bureau for Medical Services (BMS) will require board certification for all new and existing Peer Recovery Support Services personnel (PRSS).

• The West Virginia Certification Board for Addiction and Prevention Professionals (WVCBAPP) certification requirements, applications and manuals are accessible online at: https://www.wvcbapp.org/applications

• This certification differs from certifications granted in the past by the WV DHHR.

• PRSS staff must be employed by a licensed behavioral health center (LBHC), have a current CPR/First Aid card and pass a fingerprint-based background check.

• After October 1, 2022, THP will not reimburse services provided by a non-WVCBAPP certified PRSS.
Medicaid BH Reimbursement Fee Increase

• Effective July 1, 2021, BMS increased reimbursement by 70% for select behavioral health (BH) codes for the West Virginia Medicaid population

• THP updated pricing for the affected behavioral health codes as of November 15, 2021 and has reprocessed all claims dating back to July 1, 2021

• The 70% enhanced reimbursement is effective through March 31, 2022

• As of April 1, 2022, reimbursement will be reduced to 105% of the original 2021 BMS fee schedule

• The BMS’ fee schedule is available online at: https://dhhr.wv.gov/bms/FEES/Pages/default.aspx
Medicaid BH Reimbursement Fee Increase cont.

Behavioral health codes qualifying for increased reimbursement

<table>
<thead>
<tr>
<th>H0004</th>
<th>H0004 HO</th>
<th>H0004 HOHQ</th>
<th>H0004 HQ</th>
<th>H0031</th>
<th>H0032</th>
<th>H0032 AH</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0036</td>
<td>H0038</td>
<td>H0040</td>
<td>H2010</td>
<td>H2011</td>
<td>H2014 HNU1</td>
<td>H2014 HNU4</td>
</tr>
</tbody>
</table>

Contact a Medicaid customer service representative at **1.888.613.8385** should you have any questions.
Varenicline Recommended for Smoking Cessation

• The Federal Drug Administration (FDA) has approved the generic drug Varenicline for smoking cessation

• THP advises providers to write prescriptions for Varenicline instead of Chantix

• BMS covers the generic drug for the Mountain Health Trust (MHT) population

• Per BMS’ guidelines, prescriptions for Varenicline must be written for a 90-day supply

• The manufacturer of Chantix voluntarily recalled Chantix 0.5 mg and 1 mg tablets on September 16, 2021
Tobacco Cessation Counseling

Tobacco cessation counseling in dental practices (HCPCS Code D1320) is a covered service by THP

THP will expand this service April 1, 2022 to be available for members aged 12 - 64

Members will be eligible to receive one (1) unit of service per year

The counseling service will be covered outside of the $1,000 dental benefit limit for adults

Reimbursement will be based on the current 2021 Medicaid dental fee schedule

*Reminder that all dental services are administered through Skygen
LabCorp is the exclusive independent laboratory provider for THP

• Members of THP pay the lowest applicable out-of-pocket costs through the LabCorp network

• Find LabCorp locations near you at labcorp.com
Diabetic In-Home Screening

• THP has contracted with Retina Labs to provide in-home and mobile preventive services for diabetics

• Call Retina Labs at 1.866.344.2692 to assist a THP member with obtaining an appointment
CMS Establishes New POS Billing Code

• Effective January 1, 2022, the Centers for Medicare and Medicaid Services (CMS) created Place of Service (POS) code 10 (telehealth provided in the member’s home)

• Providers may begin submitting claims with this POS code immediately for MHT members

• This new POS code is applicable on DOS April 1, 2022, for THP Medicare, Commercial and Self-Funded/ASO members

• Providers should continue to bill POS code 02 (telehealth provided other than in a member’s home) for members receiving telehealth services while in a hospital or other facility that is not a private residence
Change Healthcare is Exclusive EDI Gateway

- Change Healthcare (CHC) is now the exclusive electronic data interchange (EDI) gateway for THP
- Electronic claim files (837) and electronic remittance vouchers (835) will be directed through CHC
- Use payor ID numbers 95677 or 34150
- Contact your billing service to ensure that they are submitting claims and retrieving vouchers via CHC
- Contact THP at hpecs@healthplan.org with questions
Provider Portal Enhancement

An enhancement was made to THP’s provider portal, myplan.healthplan.org, that supports the following:

- Prior authorizations, with the ability to upload documentation
- Disease and case management
- Care coordination
- Member rosters
- Quality measures/care gaps
- Hospital admission, discharge & transfer information
- Direct communication with THP clinical staff

Contact your PMC if you missed our webinar trainings
HEDIS® and Quality Measures 2022

• THP has developed documents to assist you in understanding and documenting quality of care founded on HEDIS® evidence-based measures.

• Each document includes coding guidelines and standards, as well as tips to improve your patient health outcomes and close gaps in care.

• Quality Measure Guidelines can be found on our corporate website: healthplan.org/providers/patient-care-programs/quality-measures
HEDIS® Medical Record Requests

• THP has contracted with medical record retrieval vendor Episource, LLC to retrieve the medical records selected for HEDIS® review

• A representative from Episource, LLC may be contacting you soon to schedule an appointment and to arrange the medical record collection method that is most convenient for you

• THP is requesting that providers respond within 5 days to arrange retrieval of the medical records if contacted by Episource, LLC
Improvement of HIPAA Compliant Denial Codes

The following will be rolled out in three phases: 1st: Provider, 2nd: Hospital, 3rd: Dental

- During the 2nd quarter of 2022, THP will be modifying our Health Insurance Portability and Accountability Act (HIPAA) compliant claim denial codes

- This modification will provide a one-to-one distinct Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) with every denial

- This change will provide additional clarity for providers in reviewing their remittance advice and members in reviewing their explanation of benefits

- This modification will affect all THP lines of business: Commercial, Medicare, MHT and Self-Funded (ASO) plans
Contact Information

THP Customer Service
1.888.613.8385 – MHT Products
1.800.624.6961 – All Other LOB

THP Provider Portal
myplan.healthplan.org

THP Corporate Website
healthplan.org
Thank you!
Joining the network

Enroll your NPI with Gainwell Technologies* prior to reaching out to UniCare Health Plan of West Virginia, Inc. (UniCare).

All new network contracts for UniCare require a current W9.

Send a completed Provider Application Form with updated Council for Affordable Quality Healthcare (CAQH) information when adding a new provider to UniCare.

Your effective date will be the credentialing approval date and cannot be backdated with UniCare.
Electronic funds transfer (EFT) updates

As of November 1, 2021, EnrollSafe at enrollsafe.payeehub.org replaced CAQH EnrollHub for providers to enroll or make changes to their EFT.

Billing updates and reminders

Developmental testing 96110:
• Reimbursable once per year
• If performed as part of an EPSDT visit, append EP modifier

Keep in mind, when ordering outpatient testing or referring members to a specialist, verify that the facility and provider are in-network.

Current provider and demographic information should always be on file. Any updates can be made by clicking here.
Billing updates and reminders (Cont.)

Vaccinations:
• Do not include the national drug code (NDC) when billing for vaccines to prevent denials and delayed payment.

Member balance billing reminder:
• Providers may not balance bill our members, meaning that members cannot be charged for covered services above the amount that UniCare pays to the provider. Medicaid providers may bill a member only when specific conditions have been met. These conditions can be found at the links provided below:
  o [https://provider.unicare.com](https://provider.unicare.com) > Resources > Provider Manuals, Policies & Guidelines
Billing updates and reminders (cont.)

Timely filing limit:
• Original claim submission — 180 days from date of service
• Corrected claim submission — 180 days from the original Explanation of Benefits (EOB) date

All eligibility should be verified on the Availity Portal* and/or Gainwell Technologies website prior to care being rendered.

All licensed behavioral health center (LBHC) providers must be credentialed with UniCare.
Authorization requirements for G0481 and G0482

As of January 1, 2022, prior authorization (PA) requirements have changed for G0481 and G0482. Providers must obtain prior authorization for all requests for these codes:

- CPT G0481
  - 8 to 14 drug classes
- CPT G0482
  - 15 to 21 drug classes

To request PA, you may use one of the following methods:

- Web: [https://www.availity.com](https://www.availity.com)
- Fax: 855-402-6983
- Phone: 866-655-7423
- In the request, please include the in-network servicing lab
- Authorization number will need to be shared with servicing in-network lab
Vision vendor change

Effective May 1, 2022, all routine vision and medical optometry services for UniCare members will be managed by Superior Vision:*

• Continue to submit all claims for covered services with dates of service through April 30, 2022, to VSP.
• Please note that there will be no change in the member’s benefits.
• If you have questions regarding Superior Vision, contact their Customer Service department at 877-235-5317.
Chiropractic services are covered under Medicaid and WVCHIP:

- **Medicaid:**
  - Adult — 20 visits per calendar year*
  - Children — 20 visits per calendar year*

- **WVCHIP:**
  - Children — 20 visits per calendar year*
    - Ages 16 and under require prior authorization after initial visit.

- **Claim submission:**
  - Claims do not require a referring provider.

---

* Prior authorization is required after visit limit — *Physician Certification for Chiropractic Services* form must be included with prior authorization request:
COVID-19 vaccine counseling

Effective January 1, 2022, PCPs with assigned membership may bill for COVID-19 vaccine counseling:

• CPT 99401-CR can be billed once for each UniCare member receiving COVID-19 vaccine counseling.
• Reimbursement for 99401-CR will be $75.
• Payable outside of the Rural Health Clinic/Federally Qualified Health Centers encounter rate.
• For more information, please reference provider bulletin link below:
Availity offers multiple features to help decrease your need to reach out to our Customer Care Center:

- Claim status
- Eligibility
- Direct data entry (DDE) on claims
- Corrected claims
- Prior Authorization Lookup Tool
- Remittance advice
- Provider Online Reporting — pull your member panel for your primary care providers (PCPs)
Claim dispute tool

Access the claim dispute tool through the Availity Portal at [https://www.availity.com](https://www.availity.com):

- Access the claim through the Claim Status search page.
- Select the claim you want to dispute by selecting Dispute Claim.
- Letters will be sent with final determination when the dispute is closed.
Provider communications via email

New for 2022: start receiving communications via email

Email is the quickest and most direct way to receive important information from UniCare Health Plan of West Virginia, Inc.

To start receiving email from us (including some sent in lieu of fax or mail), submit your information using the QR code to the right or via our online form (https://bit.ly/3EC5pWx).
Social Determinants of Health Provider Incentive Program

• Provider incentive payments for capturing social determinants of health needs
• PCPs eligible to participate

If your office is interested in enrolling, contact your local Provider Experience manager.
Utilization management appeal process

Appeals are accepted for up to 60 days after a denial is issued.

A physician clinical reviewer of the same or similar specialty who was not involved in any previous level of review or decision-making reviews the provider appeal.

The physician specialist may not be the subordinate of any person involved in the initial determination.

The physician specialist reviews the case and contacts the provider as necessary to discuss appropriate alternatives, render a decision, and document a decision.
Utilization review resources

Authorizations:
• Phone: 866-655-7423
• Fax: 855-402-6983 (Medical prior authorization)
• Fax: 855-402-6985 (Medical inpatient/continued stay review)
• Fax: 855-325-5556 (Behavioral health inpatient)
• Fax: 855-325-5557 (Behavioral health outpatient)

Pharmacy and medical injectable prior authorization:
• Phone: 877-375-6185
• Fax: 844-487-9290
Utilization review resources (cont.)

Grievance/appeal (authorizations only):
• Fax: 866-387-2968

Continued stay review:
• Phone: 866-655-7423
• Fax: 855-402-6985

Customer Care Center:
• Phone: 800-782-0095

Peer-to-peer line:
• Phone: 866-902-4628
Looking ahead

- Contract repapering project
- Electronic provider enrollment
Territory map

Kelly Smith
304-859-2976
Kelly.Smith@anthem.com

Kelly Reeder
304-410-3175
Kelly.Reeder@anthem.com

Linda Pennington
304-541-7120
Linda.Pennington@anthem.com

Angie Richards
304-539-2845
Angela.Richards@anthem.com

Jill Miller
304-410-2618
Jill.Miller@anthem.com

Erica Davis
276-245-5769
Erica.Davis4@anthem.com

As of October 2021

UniCare Health Plan of West Virginia, Inc.
Mountain Health Trust
* Gainwell Technologies is an independent company providing payment solutions services on behalf of UniCare Health Plan of West Virginia, Inc. Availity, LLC is an independent company providing administrative support services on behalf of UniCare Health Plan of West Virginia, Inc. Superior Vision, offered by Versant Health, is an independent company providing routine and medical optometry services on behalf of UniCare Health Plan of West Virginia, Inc.

https://provider.unicare.com
UniCare Health Plan of West Virginia, Inc.

UWVPEC-2186-22 March 2022
West Virginia BMS

NEMT

Non-Emergency Medical Transportation
Agenda

- What does ModivCare do?
- How to contact ModivCare
- Who can request transportation?
- “Travel (Distance, Trip Limits and Authorization)”
- “Notification, Advance Notice and Same Day Requests”
- Standard Trip Information
- Levels of Service Provided
- Mobility Assessment
- Durable Medical Equipment
- Covered Services
- Return Ride Home
- Service Concerns & Escalation Process
- Facility Liaison
- Exceptions Facility Department
- How to Request Standing Order Services
- TripCare
- Outreach
- Questions
- Contact Information
What does ModivCare do?

• Coordinates requests for non-emergency medical transportation (NEMT) for eligible members
• Schedules & routes NEMT for members based on their medical and mobility needs
• Contracts with, and pays, local transportation companies to perform the non-emergency medical transportation

Hours of operation for routine reservations:
• Monday through Friday, 7am to 6pm (EST)
• Routine reservations will not be accepted on national holidays

Calls for trips for urgent/same-day appointments/facility discharges and Ride Assist: 1-884-549-8354
• 24/7 – 365 days

***Members should never experience a call going to a voicemail***
How to contact ModivCare

Contact Us

• Reservations (Ride Assistance): 844-549-8353
• Facility: 844-889-1941
• Facility Fax: 844-882-5998
• Hearing or Speech Impaired: (TTY): 844-288-3133
Who Can Request Transportation?

- Member 18 yr. (or under 18 if they are emancipated).
- Parent/Legal Guardian
- Authorized Representative of Member
- Health Plan Representative
- Medical Provider
“Travel, Distance, Trip limits and Authorization”

Travel permitted in the state of West Virginia

- 125 Miles (30 miles outside of WV)
- Unlimited Trips
“Notification, Advance Notice and Same Day Requests”

Notice required for routine (non-urgent) medical appointments:
  o (5) business days

How far in advance can members make reservations?
  o 30 days
  o Members can request standing order transports more than 90 days in advance for the following treatment types:
    ▪ Outpatient therapy services
    ▪ Chemotherapy
    ▪ Dialysis
    ▪ Outpatient behavioral health service

Members/caregivers can request same-day NEMT for urgent trips such as:
  • Hospital discharge requests
  • Life-sustaining treatment
  • Radiation
  • Detox
Mobility Assessment

Callers are asked a series of questions to determine the correct level of service:

- Is the member able to walk safely to the vehicle without assistance?
- Does the member use a walker? If so, what kind of walker?
  - Walker Rollator, 4 wheeled walkers, no wheeled
- If the member uses a wheelchair, can they transfer safely to the vehicle without assistance?
- If the member requires a wheelchair-equipped vehicle, please be prepared to provide the following information:
  - The type of wheelchair (manual or electric)
  - The weight of the wheelchair
Types of Transportation and Level of Service

• **Types of Transportation**
  - Gas Mileage Reimbursement
  - Mass Transit
  - Commercial drivers
  - Independent drivers

• **Level of Service**
  - Ambulatory
  - Wheelchair
Durable Medical Equipment

A member is required to provide their own:

- Wheelchair
- Child safety/booster seats
- Any other durable medical equipment

Additional Passengers

- Member and one additional passenger (escort/guardian/attendant) are allowed on a space available.
- Attendant must be required by the healthcare provider.
- Attendant must be requested at time of the reservation.
- One escort is allowed to accompany members who are blind, deaf, Intellectually Disabled, or under 18 years of age.
- Transportation of an escort will not have an associated expense.
- A legal guardian with multiple children is allowed to ride. Must provide own car safety seat.
Return Ride Home

Member return home options:

• Schedule a set pickup time for the return home from the medical facility

• Schedule the return home as a “Will Call” and the return time is left open until the member calls us to advise they are ready to go home

  o If scheduled as a “Will Call” Provider has up to 1 hours from the time of the call to pick up Member.
Service Concerns & Escalation Process

• ModivCare’s Ride Assist Number: 844-549-8354
  - The Customer Service Representative (CSR) will attempt to resolve the issue in real-time whenever possible.
  - If the driver is running late, they will notify ModivCare and we will work with the member and Healthcare Facility to see if member can still be seen at a later time.
  - The CSR will document any complaint for further research and resolution.
  - Contact the appropriate insurance plan from the list ModivCare distributes to facilities as soon as there is a transportation issue with member i.e. late drop off, late pick up, no show, safety issues, etc.

Keep ModivCare up to date on member, i.e. several missed appointments, member no longer attends facility, etc.

Refrain from contacting transportation provider/driver directly. ModivCare strongly advises members and facility personnel against direct contact with the transportation provider/driver as this will delay ModivCare procedures and diminish the amount of information for us to investigate and assist in identifying/resolving transportation issues.
Facility/ Provider Liaison

ModivCare Facility/Provider Liaison:

• Acts as a focal point for issues, questions, or concerns that facilities and members may have.

• Coordinates with the proper company personnel/department to provide timely and accurate answers for the customers.

• Assists with complaints/issues and follows up within a reasonable time frame.

• Updates facilities and members on ModivCare processes.

• Provides facilities with information about available features such as TripCare, as well as assists in solving specific member issues with involved facility staff.

• Prompts the Facility Social Worker or responsible parties to obtain complete member addresses and accurately updates ModivCare database.

• Provides outreach via in-person meetings, WebEx, conference calls as needed or requested by facility.
Exceptions Facility Department

Modivcare Exceptions Facility Department:

- Assists facilities (i.e. nursing homes, dialysis, etc. with standing orders) in arranging and coordinating their clients’/members’ transportation needs via fax or email.
- Coordinates and schedules transportation requests for dialysis clients received by fax or email.
- Screens requests for appropriate level of care needed and service covered per insurance contracts.
- Provides consistent and timely communication with all facilities and members regarding transportation issues.
- Provides superior customer service as evidenced by handling all facility-related phone calls.
- Maintains and updates addresses, phone numbers, and fax numbers as needed.
- Coordinates recertifications and attendance reports in a timely fashion and communicates all information with the health care plan.
How to Request Standing Order Services

• Email to wvexceptions@modivcare.com
• Fax to (855)882-5998
• Request online at TripCare https://tripcare.logisticare.com
• Please allow 3 business days for standing orders and standing order changes to take effect (weekends and holidays not included)
TripCare is a one stop solution for managing patient transportation our website portal offers the following:

- User friendly website
- Manage and enter your patient’s transportation needs.
- Eliminates the use of calling in for most trips.
- Manage and see Trip Requests, Recertifications, Attendance and Reservation Details including transportation provider assignment.
- Provides resources such as state by state forms and feedback options.

The TripCare Site processes healthcare facilities NEMT requests online. This eliminates the need to call in or fax these requests.
Outreach

For further inquiries related to outreach:

• Standing orders
• TripCare: request access, training etc.
• In-service visit

• Please contact your Outreach Coordinator or Facility Liaison for further information. (Please see last slide)
Contact Information

Title:   Facility Liaison
Name:   Scott Coleman
Phone:   304-550-6389
Email:   scott.coleman@modivcare.com

Title:   Exceptions/Facilities Manager
Name:   Tiara Woods
Phone:   681-215-5110
Email:   tiara.woods@modivcare.com

Title:   Sr. Director- Client Services
Name:   Joshua McGill
Phone:   304-993-2171
Email:   josh.mcgill@modivcare.com

*Please do not give this contact information directly to members.*
Thank You
2022 Spring Provider Workshop Meetings
AGENDA

• SKYGEN Experience
• Dentures differences (D5110 and D5120) and how they affect extractions
• Covid Reprocessing (07/1/2021 through 12/31/2021)
• SKYGEN E-Payment Platform
• 2022 Code Changes for West Virginia
• Orthodontia case transfer process
• Submitting a corrected claim via Provider Web Portal/Clearinghouse/EDI
• Provider Web Portal Click to Chat Feature
• Key Statistics:
  • Provider Contracting and Credentialing
  • 2021 claims and authorizations for Children (all 3 MCO’s combined)
  • 2021 claims and authorizations for Adults (all 3 MCO’s combined)
• Miscellaneous: Addressing the difference in the CHIPS Authorization schedules
• SKYGEN dental references
SKYGEN has partnered with the three West Virginia MCO’S, Aetna Better Health of West Virginia, The Health Plan of West Virginia and UniCare of West Virginia, for the administration of dental benefits.

SKYGEN is delegated the following:

• Authorization Determination (UM Management)
• Claims Processing
• Encounters
• Appeals - Member and Provider
• Call Center - Member and Provider
• Network Development
• Credentialing
We partner with healthcare payers, delivery systems, and state regulatory agencies to administer dental and vision benefits.

50 States, including the District of Columbia

110,000+ Providers touched

10M+ Lives administered through outsourcing solutions
Access to innovative web-based tools that help reduce costs through minimized administrative tasks.

• The Provider Web Portal provides access to:
  ▪ Fast claim payment
  ▪ Electronic transaction options including direct claim submission and direct deposit
  ▪ Claim payment estimator
  ▪ Eligibility information and appointment scheduler
  ▪ Historical remittance advice
DENTURE DIFFERENCES (D5110 AND D5120) AND HOW THEY AFFECT EXTRCTIONS

• Full dentures (D5110 and D5120) will deny if they are billed prior to or on the same day with Simple/Surgical Extractions (D7111-D7250). Partials and complete dentures may not be re-based or re-lined within six (6) months of placement.

• Simple/Surgical Extractions (D7111-D7250) will deny if the date of service is after the placement of full dentures (D5110 and D5120) with the denial message 'Service not billable after full dentures'.

• Simple/Surgical Extractions (D7111-D7250) will deny if the date of service is the same date as the placement of full dentures (D5110 and D5120) with the denial message 'Service not permitted on same date of service as other procedures billed'.

• Simple/Surgical Extractions (D7111-D7250) - when 4 or more extractions are performed on the same day Pre-op & post-op x-rays, narrative of medical necessity must be submitted with the claim to receive payment.
• Claims for the dates of service between 7/1/2020 and 12/31/2020 were reprocessed starting August 2021 through November 2021.

• 700+ claims were reprocessed.
SKYGEN E-PAYMENT PLATFORM

SKYGEN E-Payment Center Option

For Providers seeking an alternative payment solution, SKYGEN is excited to introduce a new electronic payment (E-Payment) platform to accelerate and add efficiency to our claims payment process.

• By enrolling, providers have the ability to receive a no-fee Automated Clearing House (ACH) delivery of claim payments with access to remittance files via download. Delivery of 835 files to clearinghouses is available directly through the E-Payment Center enrollment portal.

• Enrollment instructions and a detailed question and answer guide are available for download at https://skygen.epayment.center/Registration.

• Follow the instructions to obtain a registration code. A customer service representative will review your registration and a link will be sent to your email once confirmed.

• For more information, please call (855) 774-4392 or email help@epayment.center.com.
## 2022 CDT Code Updates

<table>
<thead>
<tr>
<th>CDT CODE</th>
<th>PROCEDURES</th>
<th>Type of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0502</td>
<td>Other oral pathology procedure</td>
<td>BMS Deletion</td>
</tr>
<tr>
<td>D1320</td>
<td>Tobacco counseling for the control and prevention of oral disease</td>
<td>BMS fee changed to 0.00. Fee reduced to ADA Survey of Fees to keep in line with the WV State Plan</td>
</tr>
<tr>
<td>D8050</td>
<td>Interceptive orthodontic treatment of the primary dentition</td>
<td>ADA Deletion</td>
</tr>
<tr>
<td>D8060</td>
<td>Interceptive orthodontic treatment of the transitional dentition</td>
<td>ADA Deletion</td>
</tr>
<tr>
<td>D8690</td>
<td>Orthodontic treatment (alternative billing to a contract fee) Services provided by dentist other than original treating dentist. A method of payment between the provider and responsible party for services that reflect an open-ended fee arrangement.</td>
<td>ADA Deletion</td>
</tr>
</tbody>
</table>
SKYGEN is updating the current orthodontia case transfers to mimic commercial practices. The Provider A is responsible to pay Provider B.

Dr. Chris Taylor is available to assist as he has in the past, as needed.

You can reach Dr. Taylor via:

- Phone: 304.437.0640
- Email to: Chris.Taylor@skygenusa.com.
1. Log in to the Provider Web Portal.
2. Click on “Claims” (top of the menu).
3. Click on “Claim Search”.

4. Enter the claim criteria that corresponds with the claim you are searching.
5. Once claim search criteria is entered, click “Search”.
6. Click on the “Correct Claim” icon for the claim you would like to correct.

7. Once on the corrected claim page you are now able to correct any of the ADA claim form fields and add or remove documents.
Corrected claims via Clearinghouse file must include:

- Claim frequency code of 7 (Replacement) or 8 (Void/Cancel) in CLM05-3 element along with claim or encounter identifier in REF*F8 element.

- Original claim in a paid status.

- Original claim does not have previously resubmitted services or a corrected claim already processed.

- Original claim does not have associated service adjustments or refunds.

- Corrected claim must have a data match to original claim on at least three of the four items: Enrollee ID, Provider ID, Location ID, and/or Tax ID.
01/01/2021 – 12/31/2021

**Key Statistics**

- Number of Providers Credentialed: 28
- Number of Providers Re-Credentialed: 14
- Average Provider Application Turnaround time: 8 days from receipt date of all required documentation.

**Opportunities**

- Submitting your credentialing documentation on the credentialing portal will:
  - Identify missing materials as you complete your application
  - Reduce the credentialing processing period
• In December 2021 a chat feature was added to the Provider Web Portal.

• Chat inquiries are limited to registration, password resets and unlocking of accounts. Anything outside of those options are recommended to contact the portal team by calling **855.434.9239**.

• The chat saves providers time by allowing them to receive a quick response via chat box instead of calling SKYGEN's Call Center.
01/01/2021 – 12/31/2021

**Key Statistics**

- **Children** - claims processed: 282,399
  - 91% Electronic (68% EDI, 32% Provider Web Portal)
  - 9% Paper
  - Payments made in 9 days from date of receipt to date of payment

- **Adult** - claims processed: 104,959
  - 85% Electronic (59% EDI, 41% Provider Web Portal)
  - 15% Paper
  - Payments made in 14 days from date of receipt to date of payment

**Electronic Opportunities**

- Receiving payment via ACH or Virtual Card vs a paper check will decrease the time it takes to receive your money.
## Payer ID Number: SCION

### Claims Timely Filing:
- Aetna: Within 12 months of DOS
- The Health Plan: Within 180 days of DOS
- UniCare Children: Within 12 months of DOS
- UniCare Adults: Within 120 days of DOS

### Claims:
SKYGEN - WV Claims  
P.O. Box 795  
Milwaukee, WI 5320

### Corrected Claims:
SKYGEN - WV Corrected Claims  
P.O. Box 541  
Milwaukee, WI 53201

### Provider Claim Appeals:
Provider Claim Appeals  
P.O. Box 1396  
Milwaukee, WI 53201
AUTHORIZATION PROCESSING

1/01/2021 – 12/31/2021

Key Statistics

• Children – Prior Authorizations determined: 199,852
  • 94% Electronic (6% EDI, 94% Provider Web Portal)
  • 6% Paper
  • Determination made in less than 1 day

• Adult – Prior Authorizations Determined: 31,471
  • 81% Electronic (12% EDI, 88% Provider Web Portal)
  • 9% Paper
  • Determination made in less than 2 days

Authorizations are valid for 180 days from approval date

<table>
<thead>
<tr>
<th>Authorization/Retro Authorization</th>
<th>SKYGEN – WV Authorizations P.O. Box 2155 Milwaukee, WI 53201</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authorization Appeals</td>
<td>WV Authorization Appeals P.O. Box 1396 Milwaukee, WI 53201</td>
</tr>
</tbody>
</table>
• There are two CHIP Authorization Schedules

1. CHIP Hybrid Schedule –
   a. This schedule is used for **The Health Plan** members
   b. The schedule includes both MHT and CHIP authorization requirements

2. CHIP Schedule –
   a. This schedule is used for **Aetna WV and UniCare** members
   b. The schedule includes the CHIP authorization requirements only.
Contact Information:

• SKYGEN Web Portal Team – **855.434.9239** or **providerportal@skygenusa.com**.
  • Contact them for Web Portal related questions (portal registration, unlocking accounts, rosters, submitting claims/authorizations, etc.)

• SKYGEN Provider phone numbers:
  • Aetna Better Health of WV - **855.844.0623**
  • The Health Plan of WV - **888.983.4690**
  • UniCare of WV - **888.983.4686**

• Craig Keeney, SKYGEN Field Representative - **304.860.5153** or **craig.keeney@skygenusa.com**
Contact Information:

- Credentialing - **855.812.9211**, call for recredentialing questions
- Network Development/Contracting - **800.508.6965**, call for adding a location or provider, TIN change
- SKYGEN E-Payment Platform - For more information, call – **855.774.4392** or email help@epayment.center.com.
- Provider Services - email providerservices@skygenusa.com, contact them for an upcoming move, new location or billing address, TIN change, provider joins or leaves the practice, a change in office hours.

Fax Numbers:

- Credentialing - **866.396.5686**
- Network Development Contracting - **877.489.1563**
Thank You

CONNECT WITH US
SKYGENUSA.com

Visit our online Knowledge Center to access helpful tips and industry best practices to succeed in the future of benefit management.

JOIN THE CONVERSATION