2023 Virtual Fall Provider Workshops

Dates and Times - Click the Links To Register!

Tuesday, October 17 from 9:00-12:00
https://events.teams.microsoft.com/event/3134cb48-87c7-48cb-a252-480f7eccc3f37@c663f89c-ef9b-418f-bd3d-41e46c0ce068

Wednesday, October 18 from 1:30-3:30
https://events.teams.microsoft.com/event/d92a6b62-3f97-4d15-97dd-63f895852030@c663f89c-ef9b-418f-bd3d-41e46c0ce068

Thursday, October 19 from 9:00-12:00
https://events.teams.microsoft.com/event/f9194188-0b3e-4090-9287-2a46f7381ed1@c663f89c-ef9b-418f-bd3d-41e46c0ce068

Tuesday, October 24 from 1:30-3:30
https://events.teams.microsoft.com/event/9f12a1ea-9d55-489c-a3a9-7ecb7a123e58@c663f89c-ef9b-418f-bd3d-41e46c0ce068

Wednesday, October 25 from 9:00-12:00
https://events.teams.microsoft.com/event/f5b3e58-a2e1-4d5a-a6b3-96f37e919beb@c663f89c-ef9b-418f-bd3d-41e46c0ce068

Thursday, October 26 from 1:30-3:30
https://events.teams.microsoft.com/event/2c45df26-2d91-4b98-b8c9-36cb123d8ff8@c663f89c-ef9b-418f-bd3d-41e46c0ce068

Morning Session - Part 1
- WV Medicaid, WVCHIP, Gainwell Technologies
- Acentra Health, Maximus, Unicare, AETNA
- Better Health of WV, The Health Plan,
- HMS-Recovery Audit Contractor, Modivcare,
- and SkyGen

Afternoon Session - Part 2
- WV Medicaid, WVCHIP, Gainwell Technologies,
- HMS-Recovery Audit Contractor, Acentra
- Health, and WV Navigator

Questions?
WVProviderFieldRepresentative@GainwellTechnologies.com
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-OnLine Portal www.wvmmis.com
Fall 2023
Provider Virtual Workshops

Morning Session - Part 1
October 17, 19, and 25: 9:00 a.m. – 12:00 p.m.
General Overview, Public Health Emergency Unwinding Process, Policy Updates and (WVCHIP) Integration

Afternoon Session - Part 2
October 18, 24, 26: 1:30 p.m. – 3:30 p.m.
Behavioral Health Services, New Provider Types, and Community-Based Services

Melissa Nichols, Provider Services Manager
COVID-19 Update


- Testing coverage for Medicaid and West Virginia Children’s Health Insurance Program (WVCHIP) members did not change at the end of the PHE.

Effective September 11, 2023 the CDC and Advisory Committee on Immunization Practices (ACIP) released recommendations for the updated COVID vaccines to be billed under the following Current Procedural Terminology (CPT) codes:

- 91318 SARS-CoV-2 vaccine, mRNA-LNP, spike protein, 3 mcg/0.2 mL dosage
- 91319 SARS-CoV-2 vaccine, mRNA-LNP, spike protein, 10 mcg/0.2 mL dosage
- 91320 SARS-CoV-2 vaccine, mRNA-LNP, spike protein, 30 mcg/0.3 mL dosage
- 91321 SARS-CoV-2 vaccine, mRNA-LNP, spike protein, 25 mcg/0.25 mL dosage
- 91322 SARS-CoV-2 vaccine, mRNA-LNP, spike protein, 50 mcg/0.50 mL dosage

COVID administration will be allowed separately for adults through September 30, 2024.
As of September 2023, 571,538 West Virginians (WV Medicaid and WVCHIP) received coverage (approximately 34% of West Virginia’s population).

- Fee-For-Service (FFS), i.e., traditional/regular Medicaid:
  - 113,977 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:
  - 457,561 members are currently enrolled.
  - Includes eligible children, including those in foster care, adopted, or those receiving services through the Children with Serious Emotional Disorder Waiver (CSEDW); pregnant women; adult expansion; parents and caretaker relatives; and Supplemental Security Income (SSI) recipients.
WVCHIP Transition

- Effective July 1, 2023, WVCHIP covers the same benefits that are provided to children and pregnant women under the Medicaid State Plan.
- Physicians and practitioners should begin collection of copays based on the WVCHIP copay group listed on the card: Gold, Blue, or Premium.
- The amount, duration, and scope of services, including any authorization requirements established in Medicaid policy will apply to WVCHIP members in the same manner.
- BMS is in the process of updating the Medicaid Policy Manual to include WVCHIP transition changes.
- WVCHIP members will remain enrolled with MHT health plans.
- Pharmacy benefits will continue to be administered outside of managed care on an FFS basis. Express Scripts, Inc. will continue to serve as the pharmacy benefits manager for WVCHIP.
The Bureau for Medical Services (BMS) is reviewing all fee schedules with the long-term goal of aligning Medicaid and WVCHIP rates in a way that will not have a negative impact on providers. In the interim, WVCHIP will retain separate fee schedules for the following services:

- Inpatient prospective payment system (IPPS)/Diagnosis related groups (DRG) rates for acute care hospitals
- Resource-based relative value scale (RBRVS)
- Anesthesia
- Outpatient prospective payment system (OPPS)/Ambulatory payment classification (APC)
- Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC)

All other fee schedules have been aligned with Medicaid effective July 1, 2023.
What benefits are NOT included in the Medicaid managed care plans?

- Transplants
- Nursing Facility Services
- Medicaid Waiver Services*
  - Aged and disabled
  - Intellectual/developmental disabilities
  - Traumatic brain injury
- Non-Emergency Medical Transportation (NEMT)**
- Retail pharmacy
- Narcan administration
- Tubal ligations

*Please note: CSEDW is a managed care benefit; however, it is often confused as a carved out service.

**NEMT services are managed and paid for by the broker, ModivCare.
Aetna Better Health of West Virginia (formerly CoventryCares)
Sarah White, Lead Director, 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 Medicaid
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 West Virginia Medicaid and WVCHIP member online application portal changed to the West Virginia People's Access to Help (WV PATH).

- Through the portal, individuals can apply for benefits, report changes, and review benefit information. Applicants, recipients, presumptive eligibility workers, and community partners can access WV PATH at wvpath.wv.gov.

- To access WV PATH, new users will create a username and password and will receive an email with instructions on how to create WV PATH credentials. For help using WV PATH, customer service is available at 1-844-451-3515.
  - Members can access their renewal due dates and complete their renewals online by logging into their WV PATH account.
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 and WVCHIP enrolled providers have had the opportunity to determine presumptive eligibility:

- Hospitals
- FQHCs and RHCs
- Comprehensive Community Behavioral Health Centers
- Free clinics
- Local Health Department

Interested entities must:

- Be a West Virginia Medicaid enrolled provider.
- Submit a presumptive eligibility enrollment package to the BMS.
- Complete an online training course.

To begin enrollment or training or for more information, visit:
[dhhr.wv.gov/bms/Provider/HBPE/Pages/default.aspx](dhhr.wv.gov/bms/Provider/HBPE/Pages/default.aspx)
West Virginia Medicaid and WVCHIP have implemented the following three-phase approach for eligibility determinations:

- **Phase One:** West Virginia Medicaid began promoting the need for the most up-to-date contact information for their members (mailing addresses, phone numbers, and email addresses). This phase focused on outreach and members making updates to their contact information using the options below:
  - Email: dhhrbcfchangectr@wv.gov
  - Online: www.wvpath.wv.gov
  - Phone: 1-877-716-1212

- **Phase Two:** This phase began when West Virginia Medicaid received notice that the continuous enrollment requirement would end on March 31, 2023. Beginning in April 2023, member eligibility will be reviewed for ongoing coverage. It is important that members understand they will need to respond to their renewal letters to continue coverage.

- **Phase Three:** Beginning April 2023, members who are determined ineligible, or who do not complete their renewal, will begin to be disenrolled.
Verifying Medicaid Coverage

Medicaid and WVCHIP coverage is almost always from the first of the month through the end of the month. Providers may wish to check the Gainwell system on the first of each month to ensure those scheduled for an appointment that month still have coverage.

Portal Instructions:
- Sign in at [www.wvmmis.com/default.aspx](http://www.wvmmis.com/default.aspx) and click the “Verify Member Eligibility” icon on the Form Entry tab.
- Select the appropriate billing provider, if not already pre-populated, who will provide service for the member.
- Enter two rows of search criteria: Member Identification (ID), Last Name and First Name, Date of Birth, Social Security Number and click “Submit.”
- To search for eligibility by date span only, in the Inquiry Type drop-down list, select Date Span Only and click “Submit.”

Interactive Voice Response (IVR) Instructions:
- Call 1-888-483-0793 and enter 1 to enter valid NP1
- For Member Eligibility - Press 2
- To Enter Member ID - Press 1 or To Enter SSN# and DOB - Press 2
- To Enter DOS - Press 1. Enter Start Date and End Date
WV PATH: Presumptive Eligibility Users
My Account page displays the following on your Dashboard:

- Your Name, the role you are currently signed in as, and your organization.
- Click to access online Help.
- Click to return to this Dashboard.
- Click to search for an application.
- Click to change your default role if you have an organization you work with most often.
- Click to add and remove presumptive eligibilities in your organization.
- Click to view your organization’s information in WV PATH.
- Click to access applications that have been saved but not submitted, and that are expiring in the next five days.
- Click to access the 10 most recent applications that have been saved but not submitted.
- Click to access the 10 most recently submitted applications.
- Click to start a Presumptive Eligibility Determination.
- Click to access Screen for Assistance to use the screening tool.
- Click to access Programs & Services to review programs and services available from the West Virginia Department of Health & Human Resources (DHHR).
- Click a link under Other Helpful Links to access other resources.
HHAeXchange was awarded the EVV contract and went live on March 2, 2021.

All Waiver and personal care agencies must enroll their direct care workers 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 are able to submit confirmed visits and bill directly to the State through the free HHAeXchange Portal.

For more information, please visit the EVV website: dhhr.wv.gov/bms/Programs/WaiverPrograms/EVV/Pages/default.aspx
All home health care and private duty nursing agencies are required to enroll their direct care workers to receive payment for services rendered.

Claims for Home Health and Private Duty Nursing services that require EVV, must include the enrolled rendering provider’s individual national provider identifier (NPI) number and must be submitted through the State's EVV vendor, HHAeXchange.

Claims that must include rendering provider NPI numbers are as follows:

- T1000 Private Duty Nursing
- 0551 Skilled Nursing Visit
- 0571 Home Health Aide Services
- 0441 Speech-Language Pathology Therapy Services
- 0421 Physical Therapy Services
- 0431 Occupational Therapy Services
West Virginia Medicaid was approved to implement a home and community-based services (HCBS) program authorized under 1915(c) of the Social Security Act for Children with Serious Emotional Disorders beginning March 1, 2020.

- Children with Serious Emotional Disorder Waiver (CSEDW) services are available for children, youth and young adults ages three to 21 years old who meet the medical eligibility criteria for the program.

- They must have a mental, behavioral, or emotional diagnosis that meets the Diagnostic and Statistical Manual of Mental Disorders (DSM) and/or International Classification of Diseases (ICD) criteria, and the diagnosis must result in functional impairment for the member in their home, school and community.

- CSEDW services may be provided by employees of licensed behavioral health centers (LBHC) that are enrolled through Gainwell Technologies and with Aetna as a CSEDW provider. Enrollment criteria includes:
  - NPI;
  - Fingerprint background check; and
  - Proof of completion of the BMS case management courses.
BMS currently contracts with Psychological Consultation and Assessments (PC&A) as the Medical Eligibility Contracted Agent (MECA). MECA makes eligibility determinations by use of information received by the independent evaluators that a family chooses from the Independent Evaluator Network (IEN). MECA makes all eligibility determinations and issues approvals and denials.

To become a member of the IEN you must:
- Be a Medicaid billable provider,
- Be willing to purchase and administer the Behavior Assessment System for Children (BASC),
- Be a licensed independent clinical social worker, licensed professional counselor, licensed psychologist or supervised psychologist, and
- Agree to meet all required timelines per CSEDW policy.

For more information or to sign up to be an IEN member, please email CSEDW@PCAsolutions.com or PC&A at 304-776-7230.
• Effective October 1, 2022, all new and current Peer Recovery Support Specialists (PRSS) were required to obtain certification through the West Virginia Certification Board for Addiction & Prevention Professionals (WVCBAPP).

• Effective January 1, 2023, all PRSS providers were required to enroll with Gainwell Technologies. All PRSS services must include the enrolled rendering provider’s individual NPI number on the claim.
On December 29, 2022, in the Consolidated Appropriations Act of 2023, Congress eliminated the DATA-Waiver Program. All DEA registrants should be aware of the following:

- A DATA-Waiver registration is no longer required to treat patients with buprenorphine/suboxone for opioid use disorder.
- Going forward, all prescriptions for buprenorphine only require a standard DEA registration number. The previously used DATA-Waiver registration numbers are no longer needed for any prescription.
- There are no longer any limits or patient caps on the number of patients a prescriber may treat for opioid use disorder with buprenorphine.
- The Act does not impact existing state laws or regulations that may be applicable.

Providers are no longer required to send a request for review and/or send a copy of their DEA-X number. Any physician, advanced practice registered nurse, or physician assistant may prescribe buprenorphine/suboxone products as defined by the DEA.
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 managed care organization (MCO) providers) will need to revalidate
- Revalidation is based on the enrollment effective date
- West Virginia Medicaid continued to require providers to revalidate throughout the pandemic
- 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:

- Peer Recovery Support Specialists (September 23, 2022)
- Home Health Care Workers (October 7, 2022)
- Private Duty Nursing (October 7, 2022)
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.)
Check State and Federal Databases Reminder

- 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): exclusions.oig.hhs.gov/

- West Virginia Medicaid Provider Termination and Exclusion List (updated monthly): www.wvmmis.com

- Go to “Reference Material” -> “Medicaid Provider Sanctioned/Exclusion.”

- It is a provider’s responsibility to ensure they do 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. West Virginia Medicaid will stop sending paper checks in the future.

Reminder:

▪ New EFT forms are available on the West Virginia State Auditor’s website (www.wvsao.gov/) to be completed with new provider enrollment and maintenance.
The Centers for Medicare & Medicaid Services (CMS) Payment Error Rate Measurement (PERM) Program for Reporting Year (RY) 2023 are currently reviewing West Virginia Medicaid and WVCHIP claims to measure improper payments and implement corrective actions to maintain the integrity of the programs.

PERM participants cited an ERROR may receive a disallowance letter and may be required to complete the following steps:

▪ Remit a specific dollar amount for the inappropriate billing of services by entering into a repayment arrangement with the State within 30 days of the date of the final disallowance letter.

▪ Submit a plan of correction that describes how your organization will prevent the identified error(s) from recurring.

Providers who wish to appeal disallowances resulting from PERM citations must utilize the appeal process detailed in Chapter 800, Program Integrity of the Bureau for Medical Services Provider Manual.
PERM Update (Cont.)

- PERM participants who wish to appeal a disallowance must request a document desk review within 30 days of the date of the final findings letter. Requests must be accompanied by documentation demonstrating the appropriateness of the payment to be considered. The information may include service documentation or citations of agency policies to support the appropriateness of the payment.
- Failure to respond to a final disallowance letter within 30 days will result in the initiation of a lien on ALL future West Virginia Medicaid and WVCHIP payments and may result in the suspension of payments to your organization.
- BMS would like to thank all providers for your cooperation in providing the requested documentation and/or clarification of medical records within the allotted time for Empower AI, the Review Contractor, to complete the desk audit review. Empower AI received 100% of the medical records requested.
Based on the error findings to date, BMS would like to remind providers of the following that impact PERM reviews:

- Providers are required to include the individual NPI of the attending, ordering, referring and billing provider in addition to the billing/facility NPI, on all claims that are submitted for reimbursement. If the NPI is not on the claims submitted, the claims will be denied.

- When billing for IDDW Services, providers should document on the appropriate West Virginia Intellectual/Developmental Disabilities Waiver (IDDW) DD7/Direct-Support Service Log when recording services provided.
  - Example: When billing for 1:2 services, both identifiers are “2.” However, the service code/modifier is different for each, which results in a billing error during the PERM review.
  - Providers should ensure the number of units billed matches the number of units documented for the authorized services.
Policy Update

Policy Manual

Effective July 1, 2023, the West Virginia Children's Health Insurance Program (WVCHIP) will also cover the same Medicaid benefits that are provided to children and pregnant women under the Medicaid State Plan. The amount, duration, and scope of services, including any authorization requirements, established in Medicaid policy will apply to WVCHIP members in the same manner. This policy change contained in the BMS Provider Manual will apply to WVCHIP unless an exclusion policy is noted.

WVCHIP Provider Notice

Important Notice
Due to the World Health Organization declaring Coronavirus disease (COVID-19) a pandemic, the West Virginia Bureau for Medical Services (BMS) has expanded certain services and waived certain requirements that may be stated in the Medicaid Provider Manual. Please refer to the COVID-19 Alerts and Updates page for specific changes and updates.

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. Editing instructions can be found on the Nitasha Medicaid Strouters Website at: http://www.wmms.com.

Important Notice: Effective October 1, 2016, 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, 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.

Policy Manuals by Chapter

Chapter 100 - General Information Effective March 1, 2023
Chapter 200 - Definitions and Acronyms Effective November 1, 2016
Chapter 300 - Provider Participation Requirements Effective May 18, 2016
Chapter 400 - Monitor Eligibility Effective April 1, 2022
Chapter 501 - Aged & Disabled Waiver Effective June 1, 2021
Chapter 502 - Children with Serious Emotional Disorder Waiver Effective July 1, 2021
Chapter 503 - Licensed Behavioral Health Centers Effective July 15, 2018
Chapter 504 - Substance Use Disordered Services Effective January 1, 2020
Chapter 505 - Oral Health Services Effective January 1, 2021

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

https://dhhr.wv.gov/bms/FEES/Pages/default.aspx
West Virginia Medicaid and WVCHIP will follow the Consolidated Appropriations Act of 2023 and extend many of the telehealth flexibilities authorized during the COVID-19 PHE through December 31, 2024. These codes can be found in Appendix B of Chapter 519.17, Public Health Emergency Medicaid Telehealth Services Flexibilities on the BMS Policy Manual webpage at: dhhr.wv.gov/bms/Pages/Chapter-519-Practitioner-Services.aspx.

Appendix A of Chapter 519.17, Medicaid Telehealth Standard Codes Policy Manual is a listing of codes that are allowed under telehealth, there is no termination date for these codes. If you would like to submit a code for consideration to Appendix A, please contact your provider field representative at Gainwell Technologies. Quarterly reviews will be completed on all submitted requests. Appendix A may be found on the BMS Policy Manual webpage at: dhhr.wv.gov/bms/Pages/Chapter-519-Practitioner-Services.aspx.
Timely Filing

- Claims must be filed (i.e., received by BMS) within 12 months from date of service; must be on a prescribed form or through an approved electronic media transaction; and must have valid provider and member ID number and a valid date of service.
- Services not billed prior to one year from the date of service cannot be added to a claim after a claim is one year old.
- Timely filing is the responsibility of the providers and is not subject to document/desk review hearings.
- Other insurance (commercial, private) must be billed within 12 months of the date of service, not the primary insurance paid date.
Exceptions to the 12-month time limit:

- Corrected claims that were billed prior to the 12-month time limit and before 24 months from the date of service with copy of remittance advice (rejections, 824 and Return to Provider Letters are not accepted as proof of timely filing).
- Medicare primary claims billed within 12 months of the Medicare pay date with a copy or the Explanation of Medicare Benefits (EOMB). West Virginia Medicaid can pay said claim within six months after notice of disposition of the Medicare claim.
- Claims for members with backdated West Virginia Medicaid eligibility billed within 12 months of the issuance of the Medicaid card with a copy of the Medicaid card.
West Virginia Medicaid has contracted with ModivCare to manage all non-ambulance and non-emergency transport:

- 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.

Ambulance non-emergency transportation is scheduled directly with the ambulance provider and does not go through the broker or require prior authorization.

NEMT Broker phone: 844-549-8353 | TTY: 866-288-3133
West Virginia Medicaid and WVCHIP have extended postpartum care to one year. Please encourage your patients to update their pregnancy status with DHHR by:

- Email: dhhrbcfchangectr@wv.gov; or
- Phone: 1-877-716-1212

- West Virginia Medicaid and WVCHIP cover prenatal screenings during pregnancy such as sexually transmitted diseases, HIV, Hepatitis B & C, Rubella, blood type and factor, and a complete blood count.
- MCOs offer monetary and other incentives for members that keep their pre- and post-partum appointments.
Right from the Start is a statewide program that helps West Virginia mothers, and their babies lead healthier lives by offering home visitation services with a Designated Care Coordinator (registered nurse or licensed social worker).

You or your staff can refer any pregnant woman with Medicaid to Right from the Start at 800-642-8522 or by visiting the website at: www.wvdhhr.org/rfts/.
Effective September 1, 2022, West Virginia Medicaid covers surgical procedures for gender dysphoria when certain criteria are met, and prior authorization is obtained.

- Gender dysphoria is a condition defined in the DSM-V in which a person experiences clinically significant distress or impairment because there is an incongruence between their biological sex and gender identity. Gender affirmation surgeries are covered for individuals diagnosed with gender dysphoria and meeting certain criteria to align their biological sex with their gender identity.

- For a listing of covered procedures and criteria for consideration, please refer to *Chapter 519.24, Gender Affirmation Surgery*: dhhr.wv.gov/bms/Pages/Chapter-519-Practitioner-Services.aspx.
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 $1,000 yearly limit.
- A list of covered services can be found at: dhhr.wv.gov/bms/Provider/Documents/Manuals/Appendix_505CFinalApprovedEffective1.1.21.pdf.
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<th></th>
<th>THP</th>
<th>Aetna</th>
<th>Unicare</th>
<th>FFS</th>
<th>Benefit Totals</th>
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<tr>
<td>Unique members with claims CY 2023</td>
<td>9,442</td>
<td>12,212</td>
<td>12,612</td>
<td>1274</td>
<td>35,540</td>
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<tr>
<td>Unique providers with claims CY 2023</td>
<td>342</td>
<td>356</td>
<td>356</td>
<td>220</td>
<td></td>
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<tr>
<td>Total amount paid for CY2021</td>
<td>$ 2,572,515</td>
<td>$ 3,431,727</td>
<td>$ 3,611,956</td>
<td>$ 2,537,678</td>
<td>$ 12,153,877</td>
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<tr>
<td>Total amount paid for CY 2022</td>
<td>$ 4,564,569</td>
<td>$ 5,472,450</td>
<td>$ 5,527,069</td>
<td>$ 899,094</td>
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<td>Total amount paid from CY 2023 YTD</td>
<td>$ 3,173,292</td>
<td>$3,998,453</td>
<td>$3,980,369</td>
<td>$ 672,276</td>
<td>$11,824,392</td>
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<td>Total amount paid from 1/1/2021</td>
<td>$10,310,377</td>
<td>$12,902,631</td>
<td>$13,119,395</td>
<td>$4,109,049</td>
<td>$40,441,454</td>
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</tbody>
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BMS has partnered with WVU Health Affairs Institute to understand the barriers to accessing adult dental benefits and how to increase utilization.

Qualitative and quantitative data collection and analysis will be reviewed from dental providers and Medicaid members.

Dental providers may be contacted requesting an interview and participation would be greatly appreciated.
Emergency Department Billing

Emergency Department (ED), Type A: Those that are open 24/7 the whole year and should bill using CPT codes:

- 99281 ED visit, the presenting problem(s) are self limited or minor.
- 99282 ED visit, the presenting problem(s) are of low severity.
- 99283 ED visit, the presenting problem(s) are of moderate severity.
- 99284 ED visit, the presenting problem(s) are of high severity.
- 99285 ED visit, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.

Emergency Department (ED), Type B: Those that remain less active than type A are classified as type B emergency departments and should bill using HCPCS codes:

- G0380 Level 1 hospital ED visit provided in a type B ED
- G0381 Level 2 hospital ED visit provided in a type B ED
- G0382 Level 3 hospital ED visit provided in a type B ED
- G0383 Level 4 hospital ED visit provided in a type B ED
- G0384 Level 5 hospital ED visit provided in a type B ED
West Virginia Medicaid offers tobacco cessation services to assist members to discontinue use of tobacco products.

- Tobacco cessation counseling to symptomatic members is available using Current Procedural Terminology (CPT) codes 99406 or 99407.
- Enrollment in the Bureau for Public Health Quitline is mandatory and can be reached at 800-QUIT-NOW (800-784-8669).
- Drugs may be combined for concurrent use, unless contraindicated. All agents are first line therapies and will be covered up to 12-weeks.
The products covered and their daily maximum limits are:

- Nicotine gum – 24 pieces per day
- Nicotine patches – 1 patch per day
- Nicotine lozenges – 20 lozenges per day
- Nicotine inhalers – 16 cartridges per day
- Nicotine nasal spray – 12 spray bottles per 30 days*
- Bupropion – 300 mg. daily
- Varenicline – 2 mg. daily

Requests for therapy beyond the initial combined 12-week approval may be granted if continuation of therapy requirements have been met with verification from provider.
Beginning October 1, 2023, statutory amendments made by section 11405 of the Inflation Reduction Act (IRA) require West Virginia Medicaid/WVCHIP cover approved adult vaccines recommended by the Advisory Committee on Immunization Practices without cost sharing.
The West Virginia Legislature passed Senate Bill 267 in February 2023.

- Senate Bill 267 will create a “Gold Card” status for providers that may result in fewer prior authorization requests.
- BMS is working to implement these changes and will have additional information in the Spring 2024 workshop.
- We would like to encourage all attendees to complete a survey that will include questions regarding your experience with prior authorization. This survey will be sent to your email after the presentation.
The WV Legislature passed Senate Bill 476 in March 2023.

- BMS is exempt from all requirements of the Purchasing Division with respect to Managed Care Contracts.

- There will be multiple new qualifying Managed Care Organizations available for members. All new MCOs will be integrated into the auto-assignment logic for eligible members and a list of these organizations will be publicized for the purpose of self assignment by members.

- Contact the MCO directly for any questions.
To request a CPT/Healthcare Common Procedure Coding System (HCPCS) code to be added to your provider contract, please contact your provider field representative with Gainwell Technologies.

You must provide a written request that includes:

- 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.
The BMS has reorganizing Program Integrity requirements into a new Chapter, *Chapter 800, Program Integrity*. Chapters 800(a) and 800(b) will no longer be maintained.

- *Chapter 800, Program Integrity* clarifies Program Integrity requirements for Medicaid providers and ensures all providers are subject to equitable oversight and accountability.

- *Chapter 800, Program Integrity* became effective August 1, 2023, and is available on the BMS website along with responses to all public comments submitted.

- Program Integrity requirements under this chapter will apply to all services provided through the West Virginia Medicaid program. For this reason, the BMS encourages all West Virginia Medicaid stakeholders to familiarize themselves with the revised policy.
Changes to Chapter 800, Program Integrity include the modified administrative appeals process shown below which providers must follow when seeking to contest audit results issued by BMS or one of its contracted auditing vendors.
Provider appeal requests must be submitted in accordance with the timelines detailed in *Chapter 800, Program Integrity* and include documentation believed to support the appropriateness of the payment to be considered. Providers electing not to dispute audit findings or appeal outcomes have agreed with the determination and chosen to waive further appeals.
There are two types of appeals for the fee-for-service program:

- Service denials
  - Prior Authorization Contractor Reconsideration of Medical Necessity Determination - must be initiated within 60 days of prior authorization 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 that affects his/her participation in the West Virginia Medicaid program or reimbursement for a covered service.
  - Must be requested by a provider.

For full appeal details, see BMS Chapter 800, Program Integrity. Billing agents working in conjunction with providers must follow the same time frames in requesting an appeal or desk/document reviews.
Resources

West Virginia Department of Human and Health Resources, Bureau for Medical Services (West Virginia Medicaid and WVCHIP)
350 Capitol Street, Room 251
Charleston, WV 25301
304-558-1700
dhhr.wv.gov/bms/Pages/default.aspx
chip.wv.gov/Pages/default.aspx

West Virginia Medicaid and WVCHIP Fee-for-Service Fiscal Agent
Gainwell Technology (formerly Molina/DXC)
www.wvmmis.com/default.aspx

Utilization Management Contractor (UMC)
Acentra (formerly KEPRO)
wvaso.kepro.com

TPL Contractor - HMS
www.wvrecovery.com
Medicaid Managed Care (Mountain Health Trust) and WVCHIP Managed Care
Maximus – Enrollment Broker
https://www.mountainhealthtrust.com

Managed Care Organizations (MCOs)
- Aetna Better Health of WV
- The Health Plan
- UniCare

MCO Dental Benefits Manager
Skygen
www.sciondental.com

Medicaid NEMT Broker
ModivCare - Phone: 844-549-8353 TTY: 866-288-3133
www.modivcare.com
Contacts

Sarah Young, Deputy Commissioner
Brandon Lewis, Office of Enterprise Systems Director
Diana Bossie, MMIS Operations Division Director
Melissa Nichols, Provider Services Manager

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
Mountain Health Promise

Tony Richards, Program Manager
The Mountain Health Promise (MHP) Program serves specialized managed care for children and youth. Mountain Health Promise assists children in foster care, kinship care, and adoptive care. Aetna Better Health of West Virginia is the single managed care organization for MHP. For more information, please visit their website at: www.aetnabetterhealth.com/westvirginia/mountain-health-promise.html

Members eligible for the Children with Serious Emotional Disorder Waiver (CSEDW) are automatically enrolled with Aetna Better Health of West Virginia.

This year we have added individuals who previously aged out of foster care at either age 18 or 21, who are eligible in the former foster care eligibility group until age 26.
Social Determinants of Health

- Education Access and Quality
- Health Care Access and Quality
- Economic Stability
- Neighborhood and Built Environment
- Social and Community Context
Engaging Through Technology

- We are exploring more engagement through technology.
- The managed care organizations have already engaged in this by providing their members with Apps.
HealthCheck is the name for West Virginia's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. The EPSDT Program is a child preventive health component of West Virginia Medicaid. Federal law requires that state Medicaid programs provide medically necessary healthcare services to Medicaid-eligible children.
Participant Ratio

WV Participant Ratio

CMS Goal

Year

2019  2020  2021  2022

Participant Ratio

63
## Current Rates

<table>
<thead>
<tr>
<th>Preventive Medicine Services</th>
<th>New Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant &lt; 1 year</td>
<td>99381</td>
</tr>
<tr>
<td>Early Childhood (1-4 Years)</td>
<td>99382</td>
</tr>
<tr>
<td>Late Childhood (1-5 Years)</td>
<td>99383</td>
</tr>
<tr>
<td>Adolescent (12-17 Years)</td>
<td>99384</td>
</tr>
<tr>
<td>Adult (18-39 Years)</td>
<td>99385</td>
</tr>
<tr>
<td>Newborn - Initial hospital or birthing center care, per day, for E/M of normal newborn infant</td>
<td>99460</td>
</tr>
<tr>
<td>Newborn - Initial care per day, for E/M of normal newborn infant seen in other than hospital or birthing center</td>
<td>99461</td>
</tr>
<tr>
<td>Newborn - Initial hospital or birthing center care, per day,</td>
<td>99463</td>
</tr>
<tr>
<td>Developmental Screening per instrument, scoring &amp; documentation</td>
<td>96110</td>
</tr>
<tr>
<td>Brief emotional/behavioral assessment</td>
<td>96127</td>
</tr>
</tbody>
</table>
In the Gainwell System and on the paper ID card, the “termination day” always shows the end of the month.

- This can be confusing because the termination date automatically advances to the end of the following month.

Dental, Transportation, Vision is not working.

- Usually, the file is incorrect, and we need to find where it was dropped. This could be PATH, Gainwell, Kepro or Aetna (or Aetna to their providers).
What if the child’s name and/or responsible party, spelling is wrong?
  ▪ The child’s case worker is the only one that can make these changes.

What if the child needs primary care physician, specialist, dental, vision, or pharmacy services, and the card number comes up negative?
  ▪ Please call 1-888-483-0797 and ask if the child has active coverage.
Aetna member services: 1-888-348-2922
Opt-out of MHP, call Gainwell Technologies: 1-888-483-0797
Pharmacy Help Desk: 888-483-0801
To change managed care organization, contact Maximus at: 1-800-8466
ModivCare (transportation): 844-889-1936
Tony Richards
Program Manager, Office of Child Welfare
West Virginia Department of Health and Human Resources
Bureau for Medical Services
350 Capitol Street, Room 251, Charleston, WV 25301
Email: Tony.J.Richards@wv.gov
Phone: 304-352-4257
2023 Fall Provider Workshops

Medicaid, WVCHIP, and Gainwell Technologies
Provider Enrollment
Provider Enrollment: Type B Emergency Room Coverage

Type B Emergency Room Coverage

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

Effective January 1, 2021, WV Medicaid approved reimbursement for the 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
Certificate Of Need Waiver

The West Virginia Senate Bill 613 aims to update specific sections of the Code of West Virginia related to the Certificate of Need (CON) program. This regulatory process mandates that healthcare facilities and providers receive approval from the West Virginia Health Care Authority before they can provide specific health services, purchase major medical equipment, or make purchases that exceed a certain amount. The program's purpose is to control healthcare costs, improve quality and efficiency, and ensure access to health services for all residents of the State of West Virginia. The below provider types can now apply for a Certificate of Need (CON) waiver:

- Renal Center/Dialysis
- Mental Hospital less than 21 / Psych under 21
- Mental Hospital less than 21 / Psych Residential Treatment Facility
- Long Term Care / Skilled Nursing Facility
- Long Term Care / Nursing Facility
- Long Term Care / ICF/IID
- Mental Health Clinic / Behavioral Health Clinic
- Mental Health Rehabilitation
- Mental Health Rehabilitation / Child Group Residential
### Provider Enrollment: Top Submission Errors

<table>
<thead>
<tr>
<th>Error Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incorrect provider type/specialty selected</td>
</tr>
<tr>
<td>Not submitting required credentials</td>
</tr>
<tr>
<td>• Board Certification/CV3 (must match the requested specialty and include residency completion)</td>
</tr>
<tr>
<td>• American Nursing Credentialing Center (ANCC) Certification</td>
</tr>
<tr>
<td>• Professional License</td>
</tr>
<tr>
<td>Incorrect office contact information</td>
</tr>
<tr>
<td>• Prevents outreach to notify of enrollment errors</td>
</tr>
<tr>
<td>Missing or incorrect documentation</td>
</tr>
<tr>
<td>• Signature pages</td>
</tr>
<tr>
<td>• Group Link (MPE-2)</td>
</tr>
<tr>
<td>• Practice Notification or Practice Agreement</td>
</tr>
</tbody>
</table>
Provider Enrollment: Top Submission Errors

Inaccurate Application Data
- Social Security Number (SSN)
- NPI
- Date of Birth

Documentation not legible
- Please submit legible documentation with light shading
  - Make sure documentation is legible after scanned and uploaded
Provider Enrollment: How to Update EFT

• New EFT setup requires the EFT Authorization Agreement to be completed
• To change/update EFT information, please complete both the EFT Authorization Agreement and WV Medicaid/WV CHIP Direct Deposit Change forms
• Both new setup and change/updates require a bank letter or voided check to be attached with the request
• Completed forms must be faxed or mailed to:
  Provider Enrollment
  PO Box 625, Charleston, WV 25320
  Fax: 304-340-2763
• The forms to enroll or update your Electronic Funds Transfer information are available on the Health PAS-OnLine portal:
  Microsoft Word - WV Medicaid WV CHIP EFT Agreement (wvmmis.com)
  Microsoft Word - WV Medicaid WVCHIP Direct Deposit (Change) (wvmmis.com)
Provider Enrollment: Change of Ownership (CHOW) FAQs

• What is a change of ownership?
  – A CHOW occurs most frequently for a WV Medicaid and/or WV CHIP enrolled provider when the provider has been purchased by another entity.
  – In the following situations, the ownership transaction ordinarily results in a CHOW:
    Consolidation, Asset Sale or Transfer, Partnership, Leasing and/or Unincorporated Sole Proprietorship.
  – In the following situations, the ownership transaction is not a CHOW:
    Stock/membership transfer, the transfer of corporate stock or the merger of another corporation into the provider corporation, and acquisitions/mergers.
Provider Enrollment: Change of Ownership (CHOW) FAQs

• What needs to be done if there is a change of ownership?
  – The provider(s) are responsible for notifying the State fiscal agent of the CHOW. The buyer/new owner is required to notify Gainwell, in writing on provider letterhead, of the CHOW no later than 30 days prior to the effective date of the CHOW. For income tax purposes, Gainwell must be notified at least 30 days in advance about ownership changes that affect the provider’s tax identification number. Early notice will help avoid payment delays, denials and 1099 errors. A Gainwell Provider Enrollment representative will contact the provider to assist with next steps.

• Can the same NPI be used for a change of ownership
  – Yes, the same NPI can be used if agreed upon by both parties.
Provider Enrollment

- Keep contact information such as phone, fax and address current to assure proper communication
- Keep license/accreditation current upon renewal
  - Professional License
  - DEA
  - CLIA
  - JCAHO
- Keep certifications current upon renewal. **Providers may now be placed on pay hold if the record contains an expired certification.** Please login to the Health PAS-OnLine portal to view and update credentials as needed.
CLAIMS
Billing Updates

A9592 (Fluorodeoxyglucose F-18 FDG, diagnostic, per study dose, up to 45 millicuries): Effective 01/01/2023, the code has been added to all Physician, Hospitals/CAH, and IDTF contracts.

84145 Procalcitonin (PCT): Effective 01/01/2023, CPT code 84145 Procalcitonin (PCT) has been added to benefits and added to the Physician, Hospitals, APRN, Midwife, Health Department, and Independent Lab contracts.

90759 Hepatitis B vaccine (HepB): Effective 01/01/2023 CPT code 90759 Hepatitis B vaccine (HepB) has been added to the Adult Vaccines benefit.

90679 (Respiratory syncytial virus vaccine, preF, recombinant, subunit, adjuvanted, for intramuscular use) and 90678 (Respiratory syncytial virus vaccine, preF, subunit, bivalent, for intramuscular use): Effective 06/21/2023 CPT codes 90679 and 90678 for adults aged 60 and over have been added to the following contracts: Physician, Hospitals, APRN, Midwife, & Health Department.

COVID-19 Code: Effective 07/01/2023 CPT codes 0223U, 0224U, 0225U, 0226U, 0240U, & 0241U have been added to benefits and added to the Laboratory contracts with a K1 specialty.
Billing Updates

Effective 01/01/2024, Nursing Home services will transition to PDPM payment. Please be on the lookout for additional information.

0293U and 0239U: Effective 07/01/2023 code 0293U was opened in error and has been closed. The correct code is 0239U and it has been open and backdated effective to 07/01/2023.

WVCHIP Coverage Update:

Effective 07/01/2023, the West Virginia Children's Health Insurance Program (WVCHIP) will cover the same Medicaid benefits that are provided to children and pregnant women under the Medicaid State Plan. The amount, duration, and scope of services, including any authorization requirements, established in Medicaid policy will apply to WVCHIP members in the same manner. The policies contained in the BMS Provider Manual will apply to WVCHIP unless an exclusion policy is noted.
TOP 10 CLAIM DENIALS

• Duplicate claims submission
• Timely filing
• No referral or authorization
• Services not covered by plan
• No Coordination of Benefits information submitted on claim
• Claims sent to the incorrect insurance plan for processing
• Invalid Medicare Action Code
• Invalid Authorization Number Billed
• Medicare Crossover Qualified Medicare Beneficiary (QMB) processing rules applied
  – If member has QMB eligibility, Medicaid only considers the coinsurance and deductible.
• Authorization Not for Same Provider
Fee Schedules

Fee tables updates can be located on the BMS website for the below provider types/programs:

- WV Medicaid Physician's Fee Schedules

Fee Schedule Updates

- Ambulance Fee Schedule
- Ambulatory Surgery Center Rates
- Dental Fee Schedule
- DRG Weights Updates
- Drug-Free Mom and Baby (DFMB) Fee Schedule
- Emergency Department Fee Schedule
- Hospice County Rates
- Hospital OP Surgery Max Units
- Licensed Behavioral Health Center Fee Schedule

Waiver Program Rates

- Aged and Disabled Waiver (ADW) Rates
- Children with Serious Emotional Disorder Waiver (CSEDW)
- Intellectual/Developmental Disabilities Waiver (IDDW)
- Traumatic Brain Injury Waiver (TBIW)
Ways to Submit Claims for Processing

Direct Data Entry: Via the Health PAS-OnLine Portal
www.wvmmis.com


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

<table>
<thead>
<tr>
<th>Category</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>UB04 Claims</td>
<td>Gainwell Technologies</td>
</tr>
<tr>
<td></td>
<td>PO Box 3766</td>
</tr>
<tr>
<td></td>
<td>Charleston, WV 25337-3766</td>
</tr>
<tr>
<td>ADA Claims</td>
<td>Gainwell Technologies</td>
</tr>
<tr>
<td></td>
<td>PO Box 3768</td>
</tr>
<tr>
<td></td>
<td>Charleston, WV 25337-3768</td>
</tr>
<tr>
<td>CMS-1500 Claims</td>
<td>Gainwell Technologies</td>
</tr>
<tr>
<td>Reversal/Replacement Requests</td>
<td>PO Box 3767</td>
</tr>
<tr>
<td></td>
<td>Charleston, WV 25337-3767</td>
</tr>
<tr>
<td>Pharmacy Claims</td>
<td>Gainwell Technologies</td>
</tr>
<tr>
<td></td>
<td>PO Box 3765</td>
</tr>
<tr>
<td></td>
<td>Charleston, WV 25327-3765</td>
</tr>
</tbody>
</table>
Mail Paper Claims To:

Hysterectomy/Sterilization/Pregnancy Termination
Gainwell Technologies
PO Box 2254
Charleston, WV 25328-2254

Timely Filing/Appeals
Gainwell Technologies
PO Box 2002
Charleston, WV 25327-2002

All WV CHIP Claims
Gainwell Technologies
PO Box 3732
Charleston, WV 25337-3732
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
Payment Processing Schedule

Monday
- Provider bills claims
- RAs and 835s are available on Health PAS-OnLine 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
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 Health PAS-OnLine 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

Federal regulations mandate providers to submit claims no later than 12 months from date of service. The West Virginia Medicaid Program will allow 24 months from the date of service for denied claims to be billed with corrections or paid claims to be replaced provided that the claims meet the requirements including requirements in 42 CFR 447.45. (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 Health PAS-OnLine.

Claims – 3rd Wednesday of the month
Overview of direct data entry of claims submission into Health PAS-OnLine

Dates and times are posted on our Gainwell website www.wvvmis.com

Other training can be conducted upon request
## Call Center Support

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

<table>
<thead>
<tr>
<th>Department</th>
<th>Phone Number</th>
<th>Email</th>
</tr>
</thead>
<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>
</tr>
<tr>
<td>Provider Enrollment</td>
<td>888-483-0793x4</td>
<td><a href="mailto:wvproviderenrollment@gainwelltechnologies.com">wvproviderenrollment@gainwelltechnologies.com</a></td>
</tr>
<tr>
<td>EDI Helpdesk</td>
<td>888-483-0793x6</td>
<td></td>
</tr>
<tr>
<td>Pharmacy Helpdesk</td>
<td>888-483-0801</td>
<td></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>
<td></td>
</tr>
</tbody>
</table>
Health PAS-OnLine 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.
Best Practices for the Trading Partner Account

What is a Trading Partner Account?

This is the system that grants secure access for providers to manage their West Virginia Medicaid profile.

This includes:

- Management of additional TPA users
- Management of Billing Agents
- Account Information
- EDI Certification
- X12 Transactions
- Reports (Remittance, Claims in Process)
- Correspondence (Letters, messages, alerts)
- View status details, submit and adjust claims
- Finance/Payment Details
- Patient/PCP Rosters
- Participant eligibility verification
- Enrollment and Maintenance
- Authorizations
Best Practices for the Trading Partner Account

When enrolling with West Virginia Medicaid providers are required to:

• Register a Trading Partner Account
• Identify and maintain an internal administrator for their account
• Update and maintain their account users and security clearance
• Terminate internal users who are no longer affiliated with their organization in a timely manner, to safeguard their information and the information of the West Virginia Medicaid participant community.

• The person who registers the TPA is the first account administrator and can do the following:
  o Manage users
  o Add additional administrators
  o Access and update provider associations
  o Manage TPA information (i.e., demographic edits)
Best Practices for the Trading Partner Account

Risk to consider:

- Attrition impacts most employers.
- Timely termination of access removes the potential temptation and risk of unwarranted vulnerabilities, this includes the risk to your organization and the West Virginia Medicaid participant information.
- It is TPA Account users' responsibility to educate their staff to understand the system, access, and security clearance, to partner to mitigate risk and protect the information within our accounts.
- It is each of our responsibilities to take an active role in safeguarding the information at our fingertips. As technology advances so will the efforts and abilities of those who mean to defeat our security protocol. We must stay ever vigilant in our protection efforts.
Best Practices for the Trading Partner Account

Best Practice Tips:
• Early and frequent discussions within your organization
  o Do you have the right person set up as the administrator?
  o Do you have a back-up plan if our chosen administrator is unable to perform duties within the TPA, such as another user with rights to terminate and add new users if needed?
  o Who is granting access to users?
    ▪ Are they reviewing and updating the user list frequently to accommodate new hires, terminations, and changes in access?
    ▪ Does the designated administrator have a clear understanding of the security clearance they are granting to users?
    ▪ Safeguarding access to allow only “what is needed based on role” minimizes accidental and intentional modifications to things such as provider demographic and contact information, as well as creation of unauthorized users.
Best Practices for the Trading Partner Account

Best Practice Tips:

- Billing Agents and other entities should not own your Trading Partner Account.
  - Gainwell strongly encourages providers to register and maintain their own TPA.
  - Access by invitation may be given and removed as needed by the provider within the system functionality.
  - Gainwell has seen many occasions where providers have allowed the billing agent to set up their TPA and then later the relationship is termed, and the provider essentially loses access to their TPA historical information when an account needs to be termed and a new one registered.
Provider Field Representative Map

Region 1 Representative
Interim coverage:
Brandon Treola btreola@GainwellTechnologies.com
WVU: Katrena Edens kedens@GainwellTechnologies.com
Whitney Choyce wchoyce@GainwellTechnologies.com

Region 2 Representative
Brandon Treola btreola@GainwellTechnologies.com

Region 3 Representatives
Katrena Edens kedens@GainwellTechnologies.com
Michelle Ramsey mmiller222@GainwellTechnologies.com

Region 4 Representative
Stephanie Houghtaling shoughtaling@GainwellTechnologies.com

Region 5 Representatives
Whitney Choyce wchoyce@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!
Acentra Health was founded when CNSI merged with Kepro in December 2022. Headquartered in McLean, Virginia, the combined company helps government-sponsored healthcare agencies and payers expand healthcare access, enhance quality, improve health outcomes, and lower costs through clinical services, provider management, health claims and encounter processing, data interoperability, and health analytics services and solutions.
Existing Acentra 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) Waiver
- Intellectual and Development Disabilities/Intensively Supportive Setting Group Home

- School-Based Health Services
- Medical Services
- WVCHIP (Fee-For-Service)
- Socially Necessary Services
- Children with Serious Emotional Disorders (CSEDW) Waiver Assessments
- Qualified Residential Treatment Program (QRTP)
- Wraparound Services
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/SNS
• [https://portal.kepro.com](https://portal.kepro.com)

General Information
• [https://wvaso.kepro.com](https://wvaso.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: 17,587
- Aged & Disabled Waiver (ADW): 7,626
- Personal Care: 5,806
- IDD Waiver: 5,998
- TBI Waiver: 90
- Health Homes: 3,888
- NH PAS: 21,967
Medical Authorization Request Submission and Timeframes

How to request a prior authorization

- **Electronic Submission**
  - Additional benefits when requests are submitted electronically include messaging capability and updates on requests as they move through the review process.

- **Prior authorization request fax form**
  - Please note: Faxed requests are processed on a first-come, first-served basis. Providers must still access the Acentra Atrezzo portal to review determinations.
Submission Timeframes Continued

• Providers have 10 business days from the date of admission/first date of service to submit a prior authorization request for most services. There are exceptions for certain service types.

• An EOB or certificate of non-coverage should be included with all authorization requests in instances where the service is denied by the primary payer for a Medicaid covered service. Submission within 10 business days from the date the Provider receives the EOB denial or certificate of non-coverage is strongly recommended to meet retrospective review guidelines.

• The Retrospective Review Policy will be applied to requests submitted after this timeframe. Any request submission that does not meet this policy will be administratively closed and a policy denial letter generated and uploaded for download on the provider portal. Providers must access the provider portal to view the determination letter for additional information.
Atrezzo System

• Both Medical & Behavioral Health programs have been fully transitioned to Atrezzo.
• Individual training is also available per request. Please contact Acentra or email me directly at [jaspsmith@kepro.com](mailto:jaspsmith@kepro.com) with dates and times you are available.
Benefits of Utilizing Atrezzo Next Generation (ANG)

• 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.
• 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.
Creating Temporary Consumers

• Atrezzo allows providers to create temporary consumers, if the member is not found in the system due to new enrollment with Gainwell.
• Once a determination has been made on the case internal Acentra staff will be able to link the case to the new enrollment.
• If the enrollment is not available after the review, then the case will be pended for 30 days from date of submission for eligibility updates from Gainwell.
• Please note: Active member Medicaid/WVCHIP enrollment is a requirement for an authorization number to generate and export to the claims vendor system.
Tips for Successful Medical Authorizations

• Verify 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 updated 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.
Tips for Successful Behavioral Health (BH) Authorizations

• Please make sure to select the appropriate service type for the codes you will be requesting authorization for.
• Remember to attach or fax documentation that justifies medical necessity.
• Please note: The requesting and servicing provider will match and cannot be changed when submitting BH cases. Prior to case submission, please select "Change Context" in upper-left hand corner of the home page to select different NPI numbers added to your user account as needed.
• Required data fields are marked with a red asterisk except for modifiers.
Home Health (HH)  
Physical and Occupational Therapy (PT/OT) Status Reminder

• Benefits for HH and PT/OT services will start over January 1\textsuperscript{st}, 2024.
• The first case entered into Atrezzo for 2024 will need to be \textit{initial} even if member was seen in 2023.
• Initial 60 visits of HH do not require authorization however the initial case still needs entered to meet EVV requirements.
• Initial 20 visits of PT/OT do not require authorization however entering the initial case into Atrezzo is strongly recommended.
• Cases entered after the initial will be entered as established and reviewed for medical necessity.
Acentra Contact Information

**Personal Care**
- Toll Free: 844.723.7811
- Fax: 866.212.5053
- 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
- Email: wvmedicalservices@kepro.com

**Behavioral Health**
- Local Line: 304.346.6732
- Toll Free: 800.378.0284
- Fax: 866.473.2354
- Email: RES_WV_BH_SNS@kepro.com
Acentra Contact Information

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

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

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

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

TBI Waiver
- Toll Free: 866.385.8920
- Fax: 866.607.9903
- General Email: WVTBIWaiver@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
- Behavioral Health (Clinical Information for PA Requests) - 866.473.2354
Acentra Health

Accelerating Better Outcomes
Agenda

Overview

What is Mountain Health Trust?

Managed Care

Member Enrollment

Provider File

Outreach and Education
As of September 2023, there are approximately 571,538 WV residents covered by Medicaid and WVCHIP.

Mountain Health Trust (MHT) provides managed care services to approximately 79% of the state’s Medicaid membership. Populations covered under managed care include most adults and children, pregnant women, and members receiving Supplemental Security Income (SSI). The Bureau contracts with three Managed Care Organizations (MCOs) for the provision of Medicaid medically necessary services. Effective January 1, 2021, West Virginia Children's Health Insurance Program (WVCHIP) members are included in the MHT program.
Managed Care Terminology

**Fee For Service**
Members who are *exempt* from managed care are served through a Fee-for-Service delivery system administered by Gainwell Technologies.

**Managed Care**
Members who are *eligible* for managed care are served through the Mountain Health Trust or WVCHIP programs.

**Enrollment Broker**
Maximus coordinates and enrolls all eligible managed care members into a managed care organization (MCO).

**Managed Care Organization**
An MCO is often referred to as a health plan that coordinates the provision of health services through networks and case management.
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
Managed Care Service & Benefits

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 MEMBERS
- Medicaid: 97%
- CHIP: 3%
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.
Managed Care Exemptions

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.

- Exempt from Managed Care
  - Aged/Disabled Waiver
  - I/DD Waiver
  - TBI Waiver
  - Dual Eligible
  - Long Term Care
  - Spend down Program

Spend down Program
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 mails enrollment packets to all newly eligible managed care members.

Maximus enrolls members into an MCO.

MCOs will provide members with their member identification card.
Member Enrollment 2023 Cut-off Dates

Members must enroll prior to the cut-off 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.

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</table>
Enrollment *Prior* to Cut-off Date

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* cut-off date.

**Member MCO Choice**

**Cut-off Date for the Month**

**Effective Coverage Date**

Member’s effective coverage date will be the 1st day of the next month.
Eligible members have 30 days to enroll into an MCO of their choice or they will be Auto-assigned to an MCO.

A member enrolls into an MCO of their choice after cut-off date.

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

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.
Provider File

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 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
Time for a break
2023 FALL WORKSHOP
Medicaid Eligibility Redetermination

What can you do?

Help *spread the word* to your Medicaid patients! Here’s what to tell them:

- **Update contact information** — Make sure UniCare Health Plan of West Virginia, Inc. and the West Virginia Department of Health and Human Resources (WVDHHR) has current contact information. This way, they’ll be able to contact the member about their UniCare coverage.

- **Check mail** — WVDHHR will mail UniCare members a letter. This letter will let them know if they need to complete a renewal form to see if they qualify.

- **Complete renewal forms** — At your earliest convenience return the completed form to avoid a gap in coverage.
Billing Updates and Reminders

- Keep in mind that when ordering outpatient testing or referring members to a specialist, you must verify that the facility and provider are in-network.
- Current provider and demographic information should always be on file. Any updates can be made on the Availity web portal.
- 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 web portal and/or Gainwell Technologies website prior to care being rendered.
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:
  - [https://provider.unicare.com](https://provider.unicare.com) > Resources > Provider Manuals, Policies & Guidelines
Peer Recovery Support Specialists (PRSS)

- As a reminder, all Peer Recovery Support Specialists must be enrolled with Gainwell Technologies after being certified through the West Virginia Certification Board for Addiction and Prevention Professionals (WVCBAPP) prior to enrolling with UniCare.

- Effective January 1, 2023, all PRSS claims must be billed with a rendering provider NPI, or claims will be denied.

- To enroll your Peer Recovery Support Specialist providers, please email your Provider Relationship Account Manager.

For more information, please reference this [provider bulletin](#).
Availity Reminders

Availity offers multiple features to help decrease your need to reach out to our Customer Care Center, including:

- Claim status
- Claim dispute
- Eligibility
- Direct data entry (DDE) on claims
- Corrected claims
- Prior Authorization Lookup Tool
- Remittance advice
- Provider Online Reporting (POR) — pull your member panel for your primary care providers (PCPs)
- Demographic updates
- Electronic provider enrollment
- New contract requests/update tax ID
Availity Provider Data Management

What features does the Availity PDM application provide?
• Update provider demographic information for all assigned payers in one location
• Attest and manage current provider demographic information.
• Review the history of previously verified data.

Benefits of using the Availity PDM tool:
• Consistently updated data
• Decreased turnaround time for updates
• Compliance with federal and/or state mandates
• Improved data quality through standardization
• Increased provider directory accuracy
• Choice and flexibility to request data updates via the standard PDM
Digital Provider Enrollment

What features does the tool provide?
• Apply to add new practitioners to an existing group
• Apply and request a contract to enroll a new group of practitioners
• Monitor submitted applications real time with a digital dashboard
• Submit provider rosters

Complete provider enrollment with Gainwell Technologies prior to reaching out to UniCare.

Your effective date will be the credentialing approval date and cannot be backdated with UniCare.

For more information go to: Provider Data Management
Availity Authorization Request and Referral Tool

If your organization is using fax or phone to request and check the status of authorizations, we encourage you to make the switch to the Authorization Request and Referral Tool on Availity.

The prior authorization application makes it easy to submit, review, and check authorization status of medical and behavioral health requests—all in one place.

For more information: Interactive Care Reviewer

Visit the ICR learning site to view a previously recorded webcast and to view and download job aids.
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 clinical reviewer may not be the subordinate of any person involved in the initial determination.
• The physician clinical reviewer will review the case and contacts the provider as necessary to discuss appropriate alternatives, render a decision, and document a decision.

Utilization Management Contact Information: Utilization Management
Social Drivers of Health Provider Incentive Program

• This program offers provider incentive payments for capturing social determinants of health needs.
• PCPs are eligible to participate.

If your office is interested in enrolling, contact your local Provider Relationship Account Manager.
Screening, Brief Intervention, and Referral to Treatment (SBIRT)

- SBIRT is an effective tool for identifying risk behavior and providing appropriate intervention.
- By screening for high-risk behavior, healthcare providers can use evidence-based brief interventions focusing on health and consequences, preventing future problems.
- Brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change.
- Referral to treatment provides those identified as needing more extensive treatment with access to specialty care.
- SBIRT is appropriate for any patient, regardless of age, gender, or health status.
- For more information, visit our training academy: Provider Training Academy
CHIP Updates
Effective July 1, 2023, WVCHIP will cover all Medicaid benefits provided to children and pregnant women under the Medicaid state plan. The amount, duration, and scope of services, including any authorization requirements, established in Medicaid policy, will apply to WVCHIP members in the same manner, as applicable under UniCare Health Plan of West Virginia, Inc.

WVCHIP members will remain enrolled with Mountain Health Trust health plans. Pharmacy benefits will continue to be administered on a fee-for-service (FFS) basis. Express Scripts, Inc. (ESI) will continue to serve as the pharmacy benefits manager for WVCHIP but will adopt the Preferred Drug List and authorization requirements. WVCHIP members’ cost-sharing obligations (copay amounts) remain the same.

WV_CAID_WVCHIPBenefitTransition.pdf (unicare.com)
Quick Reference Guide

• To enroll or make changes to your electronic funds transfer (EFT), visit EnrollSafe.

• All routine vision and medical optometry services for UniCare members will be managed by Superior Vision. If you have questions regarding Superior Vision, contact their Customer Service department at 877-235-5317.
Provider Education Opportunities

Unicare Provider orientation is the third Tuesday of every month. Link to registration: [https://www.provider.unicare.com/west-virginia-provider/communications/news-and-announcements](https://www.provider.unicare.com/west-virginia-provider/communications/news-and-announcements)

Sign up for email communications via the QR code below.

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**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 ([unicare.ly/WVmp](unicare.ly/WVmp)).
Unicare Provider Relationship Account Manager Contact Information

• Erica Davis (WVU)
  o phone 276-245-5769 email: erica.davis4@anthem.com

• Linda Pennington (CAMC, Marrietta, Vandalia Health)
  o phone 304-541-7120 email: linda.pennington@anthem.com

• Angie Richards
  o phone 304-539-2845 email: angela.richards@anthem.com

• Jill Miller
  o phone 304-410-2618 email: jill.miller@anthem.com

• Kelly Smith
  o Phone 304-859-2976 email: kelly.smith@anthem.com

• Kelly Reeder
  o Phone 304-410-3175 email: kelly.reeder@anthem.com
* Gainwell Technologies is an independent company providing information management on behalf of UniCare Health Plan of West Virginia, Inc. EnrollSafe is a tool developed by Zelis Payments, an independent organization offering electronic fund transfer 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. Availity, LLC is an independent company providing administrative support services on behalf of UniCare Health Plan of West Virginia, Inc.

https://provider.unicare.com
UniCare Health Plan of West Virginia, Inc.
WVUNI-CD-021165-23 March 2023
AETNA BETTER HEALTH®
OF WEST VIRGINIA
Contract Changes Effective 7/1/23

- Effective 7/1/23 WVCHIP benefits will align with the WV Medicaid State plan

- Fee schedule for WVCHIP services will align with Medicaid with the following exceptions:
  - Inpatient Prospective Payment System/Diagnosis-Related Group (IPPS/DRG)
  - Resource-Based Relative Value Scale (RBRVS)
  - Anesthesia
  - Outpatient Prospective Payment System/Ambulatory Payment Classification (OPPS/APC)
  - Vision
  - Federally Qualified Health Center/Rural Health Center (FQHC/RHC)
Contract Changes Effective 7/1/23 Cont’d

• Mountain Health Promise contract updated to include youth formerly in foster care up to age twenty-six (26) who aged out of foster care while enrolled in Medicaid.
Legislative Changes

• Senate Bill 267 requires that as of July 1, 2024, all prior authorization requests and related communication be submitted via an electronic portal. This includes:
  ✓ Confirmation of request receipt
  ✓ Communication related to the status of the request
  ✓ Approval or denial of the request

• Aetna Better Health currently uses Availity for electronic prior authorization requests. We recommend practitioners and providers begin using this portal prior to the July 1, 2024 date.
Children with Serious Emotional Disorder Waiver

- ABH of WV currently has 1,362 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.
Tobacco Cessation Services

- Tobacco cessation services for Aetna Better Health of WV members are provided through the WV Tobacco Quitline.
  
  ✓ Includes counseling as well as help selecting a tobacco cessation product if desired

  ✓ For questions, please contact 1-800-QUIT-NOW (800-784-8669)
Availity Webinars

Sign up by going to AetnaWebinars.com

• Working with Aetna on Availity – 1st Tuesday of the month 2:00 – 3:30 PM

• Claim Management using Availity – 3rd Tuesday of the month 2:00 – 3:30 PM

• Authorizations on Availity – 2nd Wednesday of the month 2:00 – 3:30 PM

• Doing Business with Aetna – 2nd Tuesday and 3rd Wednesday of the month 1:00 – 2:15 PM
Availity Portal Training

- Availity offers free on-demand and live training in the Availity Learning Center (ALC). Log in and select Help & Training > Get Trained to search the ALC catalog.

- For training applicable to Aetna Better Health, just search “ABHMC” in the ALC, or “AuthRef” for quick access to all courses and training programs relating to authorizations.

https://apps.availity.com/availity/web/public.elegant.login
Provider Webinars

• New Provider Orientation Webinar – the fourth Thursday of every month at 11:00 am.
  ✓ Robust overview of the health plan departments and functions
  ✓ Q&A time with Provider Relations
  ✓ Available to any health plan provider

• Quarterly Existing Provider Education/ Updates Webinars – December 30th at 2:00 pm.
  ✓ Upcoming changes to claims payment and editing
  ✓ Healthcare Effectiveness Data and Information Set (HEDIS) updates

• RSVP to your Provider Relations Representative or by emailing ABHWV-ProviderRelations@aetna.com
Thank you!
BMS Provider Workshop

Fall 2023
Company Overview – Who We Are

HEALTH SYSTEMS
1. WVU Medicine (WVUM)
2. Vandalia Health
3. The Cleveland Clinic (CCF)

Kourtney Koscevic (1.)
kkoscevic@healthplan.org
740.699.6959

Garrett Coleman (1.)
gcoleman@healthplan.org
304.220.6394

Marjorie Burdick
mburdick@healthplan.org
304.285.6507

Nicole Morehouse (2.)
nmorehouse@healthplan.org
304.220.6392

Marsha Shahrokh (3.)
mshahrokh@healthplan.org
304.907.6646

New PMC Position
Medicaid Redetermination

Mountain Health Trust (West Virginia Medicaid and CHIP) members are required to renew their eligibility for benefits with the West Virginia Department of Health & Human Resources (WV DHHR).

Benefit renewals are occurring throughout the year, and it is important that members verify their home address to ensure they receive their redetermination packet.

Your WV Medicaid and WV CHIP members can contact and complete renewals online at wvpath.wv.gov, by phone at 877.716.1212, or by visiting a local WVDHHR office.
Telehealth Services

The Centers for Medicare and Medicaid Services (CMS) extended telehealth services until December 31, 2024. The WV Bureau for Medical Services (BMS) adopted the CMS telehealth service timeline extension for those services covered by WV Medicaid.

View a list of telehealth services for calendar year 2023 here → “List of Telehealth Services”. As CMS updates the telehealth policy, versions will be available here.

Swing Bed Reimbursement

WV Medicaid

Effective May 12, 2023, acute care and critical access hospital claims for swing beds with date of service on or after May 12, 2023 will be denied.
Effective May 12, 2023, The Health Plan reinstates copays for WV Medicaid members. Physicians and practitioners should begin collection of copays based on the service and member’s Federal Poverty Level (FPL) as in the chart below. FPL can be determined through the [WV Medicaid Management Information System (MMIS) portal](#).

<table>
<thead>
<tr>
<th>Service</th>
<th>Up to 50.00% FPL</th>
<th>50.01 – 100.00% FPL</th>
<th>100.01% FPL and Above</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital (Acute Care)</td>
<td>$0</td>
<td>$35</td>
<td>$75</td>
</tr>
<tr>
<td>Office Visit (Physicians and Nurse Practitioners)</td>
<td>$0</td>
<td>$2</td>
<td>$4</td>
</tr>
<tr>
<td>Non-Emergency Use of Emergency Department</td>
<td>$8</td>
<td>$8</td>
<td>$8</td>
</tr>
<tr>
<td>Any Outpatient Surgical Services Rendered in a Physician’s Office, Ambulatory Surgical Center or Outpatient Hospital Excluding Emergency Rooms</td>
<td>$0</td>
<td>$2</td>
<td>$4</td>
</tr>
</tbody>
</table>
Copays

**WV CHIP**

Effective July 1, 2023, copays for WV Children’s Health Insurance Program (WV CHIP) members resumed. Physicians and practitioners should begin collection based on the WV CHIP family income guidelines and copay chart located here.
WV Children’s Health Insurance Program (WVCHIP)

• Effective July 1, 2023, WV CHIP aligned its benefits with WV Medicaid.

• BMS is updating the Medicaid Policy Manual to be inclusive of WV CHIP.

• BMS is reviewing fee schedules with the long-term goal of aligning WV Medicaid and CHIP rates in a way that will not have a negative impact on providers.

• Express Scripts, Inc. (ESI) will continue to serve as the pharmacy benefits manager for THP WV CHIP members.
THP developed regional education seminars to celebrate our physicians and their staff. Attendees meet and hear from members of THP’s leadership team on topics that include:

- Quality of care measures
- Provider information accuracy
- Programs and initiatives
- Gold Card Program
- Mountain Health Trust
- Member Quality Incentives
- Member Redetermination
- Medicare Advantage/DSNP (Dual Eligible Special Needs Plan)
- DSNP Model of Care Training Attestation
- Q & A Session

Upcoming Seminars will be announced through Provider Communications
Stay current on The Health Plan’s processes and other topics that may affect your practice.

- **ProviderFocus Newsletters** are produced and distributed quarterly. Information on THP programs, systems, procedures, and guidelines are included.

- **Core Communications** are produced and distributed bi-weekly through email broadcast. Brief points focused on updates to clinical quality, policies, care coordination, and billing guidelines are included.

- **Topic Specific Provider Communications** are sent via mail or email for special notification to all providers or a subset, depending on the content.

Learn how to sign up for Provider Communications by visiting our Provider Portal at [myplan.healthplan.org](http://myplan.healthplan.org)
THP’s Provider Delivery Services (PDS) team launched podcasts exclusively for our participating providers.

**What will we discuss?**

THP’s Information Technology, Clinical Services, Provider Delivery Services, and Operations experts will be guests to talk about:

- Cyber Security
- Systems & Tools
- Data Accuracy
- ... & more!

**Ready to Listen In?**

Access the THP MyPlan provider portal on or after the release dates!

Sign up for provider communications to receive the ProviderFocus newsletter where episodes are announced.
Effective January 1, 2023, THP updated the guidelines related to review of clinical drug testing for substance use disorder and pain management programs for Mountain Health Trust members.

The Health Plan implemented the following benefit limits established by the WV Bureau for Medical Services (BMS) for drug screenings:

- Definitive drug screen (G0480) is limited to 12 tests per calendar year without authorization.
- Definitive drug testing (G0481, G0482, and G0483) will require prior authorization from the initial date of service.
- Presumptive drug screens (80305, 80306, and 80307) are limited to 24 in combination per calendar year.
- Definitive drug testing to identify drugs that do not have a specific test available (G0659) requires prior authorization from the initial date of service

To exceed the benefit limit, providers must obtain a medical necessity prior authorization and submit all supporting medical record documentation to THP.
Prior Authorization Update cont.’d

• Effective July 1, 2023, CMS implemented NCCI PTP edits between Column One codes 80305, 80306, and 80307 for presumptive test(s), and Column Two codes G0480 – G0483, and G0659 for definitive test(s).

• Providers should bill with a modifier 59 when billed together under allowable circumstances.

• Claims submitted without appropriate modifier will deny against NCCI edit rules.
MHT Behavioral Health Services

• Licensed Behavioral Health Clinic (LBHC) providers are encouraged to bill THP with the individual rendering provider NPI if that provider is credentialed with THP.

• For outpatient services, LBHC providers may utilize: Place of Service (POS) 11 – Office and/or 53 – Community Mental Health Center.
Peer Recovery Support Services (PRSS)

• Beginning **December 31, 2022**, the Bureau for Medical Services (BMS) required 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](https://www.wvcbapp.org/applications).

• 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.

• Providers were required to have an NPI by August 1, 2022.

  • **The PRSS’ rendering NPI must be on the claim as of January 1, 2023.**
PRSS Enrollment Process

• To credential with THP, individuals rendering PRSS must first complete enrollment with Gainwell Technologies (WV Medicaid fiscal agent).

• Upon completion, individuals should submit a credentialing request to THP by accessing the materials on the secure provider portal’s Resource Library.

• THP will complete an “abbreviated credentialing” process to confirm enrollment with the State has been completed and PRSS certificate is in good standing.

• PRSS provider will then be enrolled with THP and submit as rendering provider on claims. Pending no issues, provider enrollment for PRSS is completed within 10-14 days.
Healthcare Effectiveness Data and Information Set (HEDIS)

The Healthcare Effectiveness Data and Information Set (HEDIS) was developed and maintained by the National Committee for Quality Assurance (NCQA) and has become one of the most widely used set of performance measures in managed care.

HEDIS data is collected through a combination of surveys, medical record audits, and claims data. The data collected provides information regarding customer satisfaction, specific health care measures, and structural components that ensure quality of care.

How can you improve measure performance and quality of care for your patients?

Use THP’s Quality & HEDIS Measure Guideline located here. The reference guide includes information on each measure, required service/documentation, and coding tips.
THP awards plan members for healthy behaviors such as preventive health screenings and one-on-one education with a THP Nurse Navigator. Each of these movements encourages our members to take a more active role in their care. Click here to access the full Value Add booklet.

<table>
<thead>
<tr>
<th>Diabetes Outreach Program</th>
<th>Completion of a HbA1c blood test</th>
<th>$25 Gift Card</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Diabetic eye exam</td>
<td>$25 Gift Card</td>
</tr>
<tr>
<td><strong>Women</strong></td>
<td>Completion of cervical cancer screening</td>
<td>$25 Gift Card</td>
</tr>
<tr>
<td></td>
<td>Completion of mammogram for women aged 40 and over</td>
<td>$50 Gift Card</td>
</tr>
<tr>
<td><strong>Pregnant, New Moms, &amp; Mothers</strong></td>
<td>Completion of 6 prenatal visits</td>
<td>$100 Gift Card</td>
</tr>
<tr>
<td></td>
<td>Post-partum visit</td>
<td>$50 Gift Card</td>
</tr>
<tr>
<td></td>
<td>One week’s worth of prepared meals for new moms</td>
<td>$75 value</td>
</tr>
<tr>
<td></td>
<td>New baby kit</td>
<td>Baby bag, lotion, rattle &amp; burp cloth</td>
</tr>
</tbody>
</table>

Help us help your members stay healthy!
THP’s Gold Card program is designed to recognize health care practitioners who meet outpatient prior authorization volume and approval criteria by eliminating the prior authorization process for twelve months following initial Gold Card Program enrollment.

What qualifies a practitioner?
- 30 or more prior authorizations in a 12-month period.
- Obtained a prior approval percentage greater than or equal to 90%.

What provider types is this program available for?
- All participating providers in THP’s direct contracted network.
  - All States.
  - All product lines (Commercial, Self-Funded), WV Medicaid, WV CHIP, and Medicare Advantage).

THP will not require prior authorizations from that practitioner for the next twelve-month period, except for experimental/investigational services or procedures and all out-of-network service requests.
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 continues!** The SDOH program allows our care managers to learn more about the social needs of our members and refer them to appropriate social services.

<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>
**Senate Bill 267 Implementation**

- All authorization requests and related communications will be required to go through electronically via the provider portal.
- THP will update its Prior Authorization page to publish the portal addresses.
- THP will publish portal addresses on member identification (ID) cards.

**Upcoming Transition to Skygen Dental Hub**

- Skygen developed a new dental hub to replace their current provider web portal and provide enhanced functionality for reviewing claims, eligibility, and authorization information.
- Skygen anticipates rollout of the new hub and discontinuation of existing PWP platform before year end.
Dental Services

New: Gold Card Program for Dental Providers

• Effective January 1, 2024, WV dental providers who have submitted at least 30 prior authorization requests for in the previous 12 months and received a 90 percent approval rating do not require prior authorizations for the next twelve-month period.

• Process is subject to audit but shall not be punitive.

• Dental providers may request exemption from program.

• Program only applies to children’s dental benefit.
THP partnered with DisposeRx, an organization dedicated to decreasing the risks of drug diversion, to provide a tool to safely and securely dispose of expired or terminated medications.

• **What is it?**
  DisposeRx contains a powder that is non-toxic and non-hazardous.

• **Who should receive the product?**
  THP is providing DisposeRx packets free of charge to providers for distribution to members discharging from Substance Abuse Disorder (SUD) residential and other behavioral health programs.

• **How do I obtain the packets?**
  Providers can contact their area’s Practice Management Consultant (PMC) to receive a supply of packets.
Diabetic In-Home Screening

THP partnered with Retina Labs to provide in-home diabetic retinopathy screening services for THP members.

**How does it work?**

**Step 1**
The provider contacts Retina Lab’s service line at 1.888.238.2460 to provide patient details.

**Step 2**
Retina Labs will work with THP to complete member registration.

**Step 3**
Retina Labs outreach team will contact the member to schedule an in-home appointment for the diabetic eye exam.

**Step 4**
The results are read by an ophthalmologist and returned to you. The diagnostic report provides you with clear care plan recommendations for specialist referral or re-screening.
Provider Information Accuracy

Health plans are required by federal regulation, the No Surprises Act (NSA), state regulations, and the Centers for Medicare and Medicaid Services (CMS) to verify provider information. To improve accuracy of our provider directory information, THP partnered with the Council for Affordable Quality Healthcare (CAQH), Provider Directory Snapshot “Direct Assure.”

If you are a CAQH enrolled provider, log into CAQH ProView® and review and edit your profile information as necessary.

If you are new to CAQH, navigate to CAQH ProView and click on “Register Now.”

Please remember to grant THP permission to access your CAQH data, otherwise, THP cannot interface with CAQH to obtain current provider information.
It is also necessary to maintain your provider information on CMS' National Plan and Provider Enumeration System (NPPES) registry. The NPPES registry is a directory of all active National Provider Identifier (NPI) records used across the health care industry.

• Please log into your NPPES account to review and confirm your provider information.

• Visit https://nppes.cms.hhs.gov/#/ to get started.
THP’s Exclusive EDI Gateway: Change Healthcare

• Change Healthcare (CHC) is the exclusive electronic data interchange (EDI) gateway for THP.

• Electronic claim files (837) and electronic remittance vouchers (835) will be directed through CHC.

• Contact your billing service and EDI clearinghouse (if applicable) to ensure that they are submitting claims and retrieving vouchers via CHC with payer ID 95677.

• If payer ID 95677 is not utilized, you will receive rejections for “Invalid payer ID.”

• To enroll for electronic remittance, complete the Billing and EDI Authorization and Setup Form located on our secure provider portal.
Provider Portal Functions

• Submit and View Claim Status
• 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

Contact your PMC to request a demonstration of the provider portal.
Contact Information

THP Customer Service
1.888.613.8385 – Mountain Health Trust (MHT) Products
1.877.847.7901 – All Other Lines of Business

THP Provider Portal
myplan.healthplan.org

THP Corporate Website
healthplan.org
Thank you!
West Virginia
Recovery Audit Contractor (RAC) Program

RAC Provider Outreach and Education Webinar

Presented by: HMS, a Gainwell Technologies Company
Agenda

01 WV Program Integrity RAC Program Overview
02 Payment Analytics Overview
03 Provider Overpayment Notification Process
04 Reconsideration Process
05 Provider Support
06 Document Desk Review Process
WV Program Integrity RAC
Program Overview
What is the RAC Program?
The Recovery Audit Contract (RAC) Program is a federally mandated audit and recovery program, pursuant to Section 6411 of the Patient Protection and Affordable Care Act of 2010.

What is the goal of a RAC Program?
The goal of the RAC program is to reduce improper Medicaid payments while also presenting billing education opportunities to providers to improve the accuracy of claims submitted to the Bureau for Medical Services (BMS) for reimbursement.

West Virginia RAC History
HMS, a Gainwell Technologies Company (HMS) was awarded WV RAC services in 2021. Payment Analytics was the initial service implemented under RAC in WV, with first letter mailing in September 2022.

Collaboration and Communication
Ensure providers understand their role in the program and know how to contact BMS and HMS for questions and support.
Payment Analytics Overview
Payments Analytics Process

Identifies claims improperly billed, coded, or paid according to regulatory, policy and contractual and industry rules

HMS executes proprietary rules engine against paid claim data to identify improper payments

Medical record is not required to determine an inappropriate payment – identification occurs by comparing rules to claim data elements

HMS proprietary rules engine is configured with rules customized to WV OPI specific policy and direction

WV OPI approves each improper payment type prior to any RAC activity is initiated

The findings from this analysis are reported to West Virginia’s Office of Program Integrity (OPI), along with recommendations regarding proper payment of the claim.
Overview of RAC Audit Process – Payment Analytics

1. **Provider Outreach**
   - BMS Approves Audit Type

2. **Claims Sent for WV approval**
   - BMS Approves Audit Type

3. **Claims Approved With Finding**
   - Claims Approved with Finding

4. **HMS Notify Provider: Demand Notification**
   - HMS Notify Provider: Demand Notification

5. **Reimbursement or Remittance Form**
   - Repayment or Remittance Form

6. **Refund or Adjustment Lien**
   - Refund or Adjustment Lien

7. **Document/Desk Review**
   - Document/Desk Review

   - Reconsideration to HMS
   - provider notification
   - demand notification
   - review document / desk review

Gainwell Technologies Proprietary and Confidential
Overview of RAC Audit Process – Payment Analytics

**Demand Notification**
- Demand Notification letter will be mailed to provider with HMS reconsideration instruction
- Providers will have 30 days to submit a reconsideration to HMS if they disagree
- If providers agree with the finding, you have the option to request a lien, refund the overpayment to BMS or request other options for lien and payment
- If the HMS reconsideration is upheld, you have the option to request a Document/Desk review with BMS within 30 days
- If you submit a refund check, you are required to include the Remittance Form attached to the refund check
- If you do not submit a refund check or request a repayment plan, and agree with the finding, the claim will be offset. If you agree and wish to request a repayment plan, you must notify BMS within 30 days of the HMS Demand Notification or your claim will be offset (lien)
Provider Overpayment Notification Process
Demand Notification

Based on RAC determination a notice is sent to the provider informing them of the results.

If you agree, you are required to submit a refund or request a repayment plan in the form of a refund check, payment plan, or lien (offset) schedule.

It’s possible you may disagree with the audit findings. We include detailed instructions for requesting a reconsideration to HMS in the notice you receive.
Demand Notification Letter

- Indicates that a claim review resulted in a finding of inaccurate billing and provides reconsideration instruction to HMS

- The notification letter is comprised of:

01. Cover letter

- Instruction for provider agreement
  - Refund check submitted with Remittance Form
  - Repayment Plan request with Repayment Form
- Instructions for requesting:
  - Reconsideration in writing
  - Request must be received within 30 days

02. Audit Detail

- A listing of all claims reviewed and indication of whether each claim was approved or identified as an overpayment.
- Each claim overpayment will provide specific information to explain why it was overpaid.
Request a repayment plan within 30 days of the receipt of the Demand Notification letter.

The Repayment Form is included in the Demand Notification Letter and must be utilized to request a repayment plan, requesting a lien (offset), or requesting a recovery schedule, schedule is not to exceed 12 months.

If a request for a repayment is not received timely (60 days), a lien will be initiated to recover the overpayment.
West Virginia Medicaid Standard Repayment Provision for All Overpayment Notifications

Provider Name:  
Provider NPI:  
Case Number:  
Principal Amount of Repayment:  $

Please select which of the following options you wish to use to repay the above overpayment. Sign, date and return this form.

☐ Payment within sixty (60) days after notification of the overpayment.

☐ Placement of a lien by BMS against further payments for Medicaid reimbursements so that recovery is effectuated within 60 days after notification of the overpayment.

☐ A recovery schedule over ______ months (not to exceed (12) months), through (select one method below):
  ☐ Monthly reductions in payments by West Virginia Medicaid against future claims or
  ☐ Monthly check remittance.

When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as an image transaction. For inquiries, please call 1-866-243-9010.

When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account as soon as the same day you make your payment, and you will not receive your check back from your financial institution.

This form must be returned to Bureau for Medical Services, Office of Program Integrity, 350 Capitol Street, Room 251, Charleston, West Virginia 25301-3710 no later than thirty (30) days after the date of this notification. If it is not returned, the Bureau for Medical Services will establish a lien against all future Medicaid payments until the overpayment is recovered with interest accruing sixty (60) days after the original notification and take any other necessary actions to assure recovery. Checks should be made payable to the Bureau for Medical Services.

Signature __________________________________________  Date ____________________________
Provider Agreement – Refund Check

Submit a refund check to Bureau for Medical Services within 60 days of receipt of the Demand Notification letter. Intent to make a payment must be submitted within 30 days of the Demand Notification letter.

A Remittance Form/Voucher is included in the Demand Notification Letter and must be included with the refund check.

For accurate processing, please include the Case Number on your check.
Remittance Form/Voucher

Provider Name: ________________  Overpayment Amount: $ __________
Provider NPI: ________________  Amount Remitted: ________________
Case Number: ________________  Check Number: ________________

Make checks payable to: Bureau for Medical Services

Please mail to: Bureau for Medical Services
Office of Program Integrity
350 Capitol Street, Room 251
Charleston, West Virginia 25301-3710

edited 08/01/2023

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ENSURE ACCURATE PROCESSING
PLEASE INCLUDE THE CASE NUMBER ON YOUR CHECK
AND ENCLOSE THIS VOUCHER WITH YOUR CHECK
Reconsideration Process
Option will be provided to rebut a RAC finding. If a rebuttal is submitted, HMS will respond to you in writing with an uphold or overturn decision.

If you disagree with the uphold decision, the Reconsideration Uphold letter will provide instruction to request a Document/Desk review within 30 days of receipt of the determination.

Providers are encouraged to call HMS Provider Relations (866-765-7416) to discuss and resolve issues.
Reconsideration Response Letters

**Exhaust Letter**
- Notification of late reconsideration request submission

**Overturn Letter**
- Review of documentation identifies no findings of improper billing
- No further action needed

**Uphold Letter**
- Review of documentation concludes that initial determination was accurate
Provider Support
Open Communication

- HMS encourages providers to contact us with their concerns and questions

- We view our one-to-one discussions as ideal opportunities to provide education, answer any questions and alleviate concerns

- Our Provider Relations team stands ready to guide you throughout the entire process
Provider Support

HMS Provider Relations Line 866-765-7416

HMS Provider Portal https://hmsportal.hms.com/

BMS Office of Program Integrity 304-558-1700

Letter inquiries

Process questions

Claim status verification
Document Desk Review Process
Instruction will be included in the Reconsideration Uphold Letter

Request for a Document/Desk Review must be received within 30 days of the Reconsideration Uphold Letter

Submit to:
Bureau for Medical Services
Legal Department – Document Desk Review
350 Capitol Street, Room 251
Charleston, WV 25301-3706
Thank you
Agenda

What does ModivCare do?

How to contact ModivCare

Who can request transportation?

Trip requests and requirements

Standing orders

Service concerns

Departments

TripCare

Outreach

Contact information
What Does ModivCare Do?

Coordination of NEMT requests for eligible members

Scheduling and routing NEMT based on medical and mobility needs

Contracts with local transportation providers to provide NEMT

Pays transportation providers for NEMT services provided
How to Contact ModivCare
Routine Reservations

• Call 844-549-8353
• Accepted Monday through Friday, 7 AM to 6 PM Eastern
• Not accepted on national holidays
• Should be made at least 5 business days in advance
• Can be made up to 30 days in advance

Ride Assist/Where’s My Ride

• Available for urgent/same day requests and facility discharges
• Call 844-549-8354
• Available 24/7/365
• Members should never experience a call going to voicemail
How to Contact ModivCare

- Routine Reservations: 844-549-8353
- Ride Assist: 844-549-8354
- Facilities: 844-889-1941
- Facility Fax: 844-882-5998
- Hearing/Speech Impaired/TTY: 844-288-3133
Who Can Request Transportation?

- Adult member 18 or over
- Emancipated minors
- Parent/legal guardian
- Authorized representative of member
- Health plan representative
- Medical provider
Trip Requests and Requirements
Travel, Distance, Trip Limits, and Authorization

- Travel is permitted up to 125 miles one way within the state of WV, and up to 30 miles out of state
- One trip per household per day
- Unlimited trips: no monthly/yearly/lifetime cap on total number of trips
One-Time Trip Requests

5 business days advance notice required for routine (non-urgent) medical appointments

Reservations can be made up to 30 days in advance

Same-day reservations can be made for urgent trips

- Hospital discharge
- Radiation
- Detox
- Other life-sustaining treatment
Types of Transportation

• Gas Mileage Reimbursement
• Mass Transit
• Commercial Drivers
• Independent Drivers

Levels of Service

• Ambulatory
• Wheelchair
Mobility Assessment

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

• Is the member able to walk safely to and from the vehicle without assistance?
• Does the member use a walker? If so, what kind?
• Does the member use a wheelchair?
  • Can they transfer to a vehicle without assistance?
  • What type of wheelchair?
    • Manual
    • Electric
  • What is the weight of the wheelchair?
Durable Medical Equipment

Members are required to provide their own:

- Wheelchair
- Walker, cane, and other walking assistive devices
- Child safety seats (car seats)
- Oxygen
- Other durable medical equipment
Additional Passengers

• Member and one additional passenger (escort/guardian/attendant) are allowed
• Must be requested at time of reservation
• One escort is allowed to accompany blind, deaf, intellectually disabled, or minor passengers
• Attendant must be required by medical provider
• No associated expense with transportation of escort
• A legal guardian with multiple children is allowed to ride, but child safety seats must be provided by member
Return Ride Home

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

• Schedule the return home as a “Will Call”
  o The return time is left open until the member calls us to advise they are ready to go home
  o Provider has up to 1 hour from the time of the call to pick up Member.
Standing Order Requests

- Available for:
  - Outpatient therapy services
  - Chemotherapy
  - Dialysis
  - Outpatient behavioral health services
- 3 business days notice required for new requests or changes
- Can be booked up to 90 days in advance
- Must be submitted by medical provider
Requesting Standing Order Services

• Must be requested by medical facility
  o Email to wvexceptions@modivcare.com
  o Fax to 855-882-5998
  o Request online through TripCare
  o Standing order requests CANNOT be phoned in

• Please allow 3 business days for standing order requests or changes to take effect (excluding weekends and holidays)
Service Concerns
Service Concerns and Escalations Process

ModivCare’s Ride Assist Number: 844-549-8354

• Resolves issues in real-time whenever possible
• Documents complaints for further research and resolution.
Service Concerns and Escalations Process

If a driver is late, the driver will notify ModivCare to see if member can still be seen at a later time.

Members, providers, and facilities should notify ModivCare if there is a transportation issue with member i.e. late drop off, late pick up, no show, safety issues, etc.

ModivCare needs to be informed if member arrives through other means of transportation, (i.e. family member, public transportation) and still needs the B-leg. (B-leg automatically cancelled if A-leg is not used).

Keep ModivCare up to date on member, i.e. many missed appointments, member not attending 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.
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
Facility/Provider Liaison

• Acts as a focal point for issues, questions, or concerns that facilities, providers, 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, virtual meetings, conference calls as needed or requested by facility
TripCare

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
Outreach
Outreach

For further inquiries related to outreach, including:

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

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

Facilities Liaison
Amanda Morgan
(304) 290-4325
amanda.morgan@modivcare.com

Exceptions/Facilities Manager
Tiara Woods
(681) 215-5110
tiara.woods@modivcare.com

Sr. Director-Client Services
Josh McGill
(304) 993-2171
josh.mcgill@modivcare.com
AGENDA

• SKYGEN Experience
• Prior Authorization Legislation – SB267
• Gold Card Program
• Orthodontia Continuation of Care Reminder
• Submitting a corrected claim via Provider Web Portal/Clearinghouse/EDI
• Contracting Reminders
• Credentialing Reminders
• Addressing the difference in the CHIPS Authorization schedules
• Timely Filing Rules for Each MCO
• Go Electronic!
• SKYGEN dental references
SKYGEN has partnered with the three West Virginia Managed Care Organizations for the administration of dental benefits: Aetna Better Health of West Virginia, The Health Plan of West Virginia and UniCare of West Virginia.

SKYGEN is delegated the following:

- Authorization Determination
- Claims Processing
- Encounters
- Appeals - Member and Provider
- Call Center - Member and Provider
- Network Development
- Credentialing
All prior authorization request communication must be handled electronically (bi-directionally), including status of review

- Portal web address must be included on member card.

Any incomplete prior authorization must be reviewed and returned to provider within 2 business days.

- The provider has 3 business days to submit additional information or the authorization request can be closed. If submitted timely, prior authorization must be reviewed/decided upon within 2 business days of additional documentation.

If prior authorization is submitted cleanly, requests must be responded to within 5 business days (for a standard authorization) or 2 business days (for an urgent authorization).

If a peer-to-peer appeal of a prior authorization is requested, the peer-to-peer must be completed within 5 business days. If peer-to-peer is not requested, the appeal must be completed within 10 business days of the day of submission.
Effective January 1, 2024, the Gold Card program is being implemented by SKYGEN. This process allows a health care practitioner (West Virginia dental provider) who has submitted at least 30 authorization requests in the previous 12 months and has received a 90 percent approval rate on authorizations to not require prior authorizations for the next twelve-month period.

• The program is available to all participating West Virginia providers in SKYGEN’S contracted network product lines (WV Medicaid, WV CHIP, and Foster Care). This exemption is subject to internal review at any time.

• SKYGEN Provider Outreach Specialists/Field Representatives will contact the practitioners who have qualified for the Gold Card Program and notify them of their effective date.

• Practitioners are still responsible for checking member eligibility and benefits during Gold Card Program enrollment.

• Gold Card status will be awarded per plan, meaning a provider may qualify for Gold Card status for Plan 1 but not Plan 2.
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](mailto: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.
Contracting is the first step when joining SKYGEN and is an agreement with a business, not an individual.

- Contracting takes approximately 3 business days AFTER SKYGEN has received all necessary documentation.

- Once contracting is completed, the provider will receive an email from SKYGEN. Once you receive that email you may begin the credentialing process.

**Remember!**

- Always contact the contracting department when adding doctors.
- Contact Provider Services when updating email addresses, phone numbers, office hours, etc.
Credentialing occurs every three years.

- Credentialing takes approximately 30 days *AFTER* SKYGEN has received all necessary documentation.
- Once approved/denied the provider office will be notified within one week via mail.

**Opportunities**

- Submitting your credentialing documentation on the credentialing portal will:
  - Identify missing materials as you complete your application
  - Reduce the credentialing processing period
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 Mountain Health Trust 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.
Aetna Better Health
- Adults – 365 days*
- Children – 365 days*

The Health Plan
- Adults – 180 days*
- Children – 180 days*

Unicare
- Adults – 120 days*
- Children – 365 days*

*Timely filing may change on claims w/ primary and secondary insurance. The MCOs understand that it takes time for primary insurance to process the claim and send an Explanation of Benefits. Unicare, Aetna and The Health Plan are still determining what that extension after receipt of the primary EOB will be.
GO ELECTRONIC!

Claims

• The average time to process a claim is 13.5 Calendar days (Receipt to payment)

Authorizations

• The average time to process an authorization is less than 1 day (receipt to finalization)

Provider Payments

• Electronic payments made in 9 days from date of receipt to date of payment.
Contact Information:

SKYGEN Web Portal Team – 855.434.9239 or providerportal@skygenusa.com

• Contact the Web Portal Team for all website 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](mailto:providerservices@skygenusa.com) with information on changes related to the practice. This includes an upcoming move, new location or billing address, TIN change, provider joins or leaves the practice, a change in office hours, etc.

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