On May 2, 2013, Governor Earl Ray Tomblin announced West Virginia would expand Medicaid coverage to individuals 19 to 64 years of age whose income is up to 138% of the Federal Poverty Level (FPL). It is anticipated the expansion will result in over 90,000 additional West Virginian’s being eligible for Medicaid coverage. Combined with other Affordable Care Act mandates, the number of uninsured West Virginians is expected to drop from 246,000 to 76,000 by 2016.

Expansion results in $5.2 billion in federal funds entering the state economy from FY 2014 through FY 2023. Due to the increased federal funds coming into the state, the health care sector will see increased economic activity. The State currently spends approximately $12 to $15 million per year in uncompensated care. As more individuals have insurance coverage, uncompensated care will dramatically decrease.

For the baseline Medicaid program, services except for behavioral health, personal care, pediatric dentistry, and Non-Emergency Medical Transportation are already in the State’s managed care system. To effectively control costs, the Bureau for Medical Services (BMS) will move these remaining pieces of services into managed care for both the current and the expanded population. Managed care results in better coordination of services to improve health outcomes.

The expanded use of managed care, particularly related to substance abuse and behavioral health, can aid in reducing the State’s substance abuse problem and creating other cost savings, freeing up resources that may be used for the State’s expanded population Medicaid match.

Medicaid will explore strategies to promote personal responsibility among members. These strategies will include developing co-payments for services and exploring premium assistance which will reduce cost and improve quality.

During the next few weeks the BMS will be preparing State Plan Amendments to expand the Medicaid population, expand the use of managed care and develop co-payment for Medicaid services. Enrollment will start on October 1, 2013 with services beginning on January 1, 2014.

To keep informed about the progress of Medicaid expansion check the Medicaid expansion section at http://www.dhhr.wv.gov/bms/Pages/MedicaidExpansion.aspx on the BMS website.
Molina Medicaid Solutions and the Bureau for Medical Services are pleased to announce the implementation of our new Internet-based Provider Enrollment Application Portal (PEAP). This application system will speed up the enrollment process. It also allows for electronic signatures.

With the implementation of the Internet-based PEAP system, the provider revalidation process will begin. CMS requires BMS to conduct and complete this process to ensure our records are current and maintained. Molina will take this opportunity to meet additional Federal Regulations as defined in the Affordable Care Act (ACA). One example of the additional requirements implemented under ACA requires enrollment of providers who order/refer/prescribe, such as hospital residents. Historically, WV Medicaid has not been mandated to enroll this type of providers.

The provider revalidation process will be conducted in phases by provider type. Providers will receive a letter notifying them of their scheduled revalidation. This letter will be time sensitive and contains a unique case number that will be required to begin the revalidation in the PEAP system. Providers should not revalidate until they receive their letter with a case number. Any provider application submitted via the Internet-based PEAP system will require the user completing the application to provide an email address for the authorized/delegated official who will sign the application as part of the submission process.

BMS and Molina Medicaid Solutions will be updating their websites with more information on the schedule for implementation of PEAP and the provider revalidation process as time gets closer. Molina will be providing training, PEAP User Guides and reference materials to provide education on this process. Please be sure to check the Provider Enrollment link on Molina’s website (www.wvmmis.com) periodically to make sure you are up to date on the implementation of the Internet-based PEAP system, and the provider revalidation process.

**EHR Incentive Payments**

March 31st, 2012 was the last day for eligible professionals to register and attest to receive a Medicaid incentive payment for calendar year (CY) 2011. In the first payment year, an eligible professional must attest to Adopt/Implementation/Utilization (AIU) to certified EHR technology. In the second payment year, the eligible professional must demonstrate Meaningful Use (MU) of certified EHR technology for a continuous 90 day period within that program year. For the third and subsequent years, the eligible professional must demonstrate MU for the entire calendar year (365 days). For each program year, the eligible professional must meet patient volume requirements for a continuous 90 day period in the preceding calendar year.
Electronic vs. Paper Billing

Medicaid claims that are secondary to insurance or Medicare coverage, including Medicare HMOs, may be billed electronically either through electronic vendors or through Molina's web portal. Contact the EDI Help Desk for access to submitting claims on the web portal.

Medicare Primary Claims
Many Medicare primary claims crossover to Medicaid automatically from the Medicare Part A and Part B carriers through the Coordination of Benefits Agreement (COBA), but some do not. Claims that do not crossover, and therefore must be billed separately by providers include:

- Outpatient claims from Part A Medicare carriers (such as NGS)
- Long Term Care (LTC) claims from Part A Medicare carriers
- Anesthesia claims from Part B Medicare carriers (on crossover, these are rejected because claims are billed in "minutes" not "units")
- Claims processed by Medicare HMOs.

All of these types of claims may be billed electronically to Medicaid. Medicare paid amounts, deductible amounts, and coinsurance amounts are required for Medicare approved services and Medicare Action Codes are required for services denied by Medicare. This information is required at the claim line level for professional services billed on the 837P format and at the header level for institutional services billed on the 837I format.

- Allowed amount, paid amount, deductible, and co-insurance information must be billed in the Medicare segments, not the TPL segments, or the claim will not process correctly.
- Medicare HMO co-pay amounts are to be billed as deductible.
- Claims denied by Medicare HMOs may be billed electronically if the denial is a HIPAA compliant denial code or Medicare Action Code (MAC).
- Denied claims that are not denied with a MAC must be billed on paper with copy of EOMB including the denial reason in addition to the denial code.
- All Medicare HMO claims billed on paper must have "Medicare HMO" written on the EOMB to assure correct processing.

Third Party Liability—TPL Primary claims
Providers must seek reimbursement from private insurance prior to billing Medicaid. These secondary claims may be billed electronically if the insurance carrier approved the service. Claims that were denied by the primary carrier, or contain denied claim lines, must be billed on paper with a copy of the EOB that includes a description of the denial in addition to the denial codes.

Medicare and TPL Claims
If a member has Medicare and TPL coverage, claims may be billed electronically if both carriers made payments for the service.

Please note: Providers may call the HMS at 877-598-5820 to check to see if there is a record of primary coverage by another carrier. If a member has Medicare and TPL coverage, claims that cross from Medicare should deny for the insurance payment or denial information. If Medicaid has no record of the insurance coverage for the member, the claim will process for payment which can cause a problem with an overpayment. You may report the insurance coverage to the TPL Unit at the Bureau for Medical Services, 304-558-1700, who will correct the member’s record so future claims will process correctly.
NDC Billing Instructions

Molina EDI Help Desk reports that claims are being rejected because more than one NDC code is being billed on one service line. Below you will find instructions on billing multiple NDC codes for the same drug on a claim.

For more detailed information on billing NDC codes, please see the BMS website at www.dhhr.wv.gov/bms under the heading “HCPCS/Drug Codes”.

NDC’s must be configured in what is referred to as a 542 format. The first segment must include five digits, the second segment must include four digits, and the third segment must include 2 digits. If an NDC is missing a number on the product label, the appropriate number of zeros must be added at the beginning of the segment. Only the NDC as specified on the label of the product that is administered to the member is to be billed. Every NDC must be billed with an N4 qualifier before the NDC with no hyphens or spaces, the unit qualifier such as F2 (International Unit), GR (Gram), ML (Milliliter), and UN (Unit) and the NDC quantity. Billing instructions are available at www.dhhr.wv.gov/bms & Molina Medicaid Solutions at www.wvmmis.com.

Important: All NDC charges must have the specific date of service the listed drug was administered and all NDC drug charges must be listed individually.

Multiple NDCs

At times, it may be necessary for providers to report multiple NDCs for a single procedure code. For codes that involve multiple NDCs (other than compounds, see BMS website), providers must bill the procedure code with KP modifier and the corresponding procedure code NDC qualifier, NDC, NDC unit qualifier, and NDC units. The claim line must be billed with the charge for the amount of the drug dispensed for the NDC identified on the line. The second line item with the same procedure code must be billed utilizing KQ modifier, the procedure code units, charge and NDC information for this portion of the drug.

Prevnar 13® Immunization

Effective 12/30/2011 Prevnar 13® is available for WV Medicaid members over the age of 50. Prevnar 13® is FDA approved for adults 50+ years of age to help prevent pneumococcal pneumonia, meningitis, and bacteremia caused by 13 strains of S pneumonia. CPT code 90670 is to be billed for adult vaccinations; the reimbursement includes the cost of administration – the immunization administration codes are not to be billed separately for adult vaccines.

Prevnar 13® is currently available for children up to the age of 6 through the Vaccines for Children (VFC) Program. As with all VFC vaccines, bill the administration code with your charge for the service and the vaccine code with the SL modifier to indicate the vaccine was provided under the VFC Program at no cost.

PAAS Referral Numbers

The PAAS Referral Number is the Legacy Medicaid Group number unless the provider is in a solo practice. There are many instances where claims will deny because the Physician’s individual number is given in place of the group number. The PAAS approval number is to be billed as follows:

- CMS 1500: PAAS number in field 19
- UB04: PAAS number in field 78

The provider must also use the appropriate qualifier when entering the PAAS number:

- Legacy Number: 1D qualifier
- NPI Number: XX qualifier
Attention Anesthesia Providers

Anesthesia time MUST be billed in 15 minute time increments, NOT in individual minutes. As of May 1, 2012, electronic claims with MJ qualifier indicating minutes are being rejected to the submitter. This includes claims crossed over from Medicare. Medicare primary claims must be submitted by the provider electronically or on paper and must be billed in 15 minute increments. See the Practitioner Services Manual (Chapter 519) concerning rounding units to whole numbers. Also note that anesthesia modifiers AA, AD, QK, QX, QY or QZ must be billed to indicate the supervising status of the practitioner and QS must be billed when appropriate to indicate monitored anesthesia.

Multiple Evaluation and Management on Same Date of Service
By the Same Provider

Only one E&M procedure may be billed when more than one practitioner in the same specialty and same group provides a service to the same member on the same date of service, unless the E&M services are for unrelated problems. When multiple E&M visits occur on the same date of service, the practitioner must bill with the E&M procedure code that best represents the combined level of services.

Change in Claim Form for ASC Services

Effective for dates of service on or after June 1, 2013, all Ambulatory Surgery Center (ASC) providers must submit claims for services rendered for WV Medicaid members using the CMS 1500 claim form or its electronic counterpart. This change is required to support WV Medicaid’s implementation of the Medicaid National Correct Coding Initiative (NCCI). The transition to the CMS 1500 claim form for ASC services is restricted only to the claim form and does not alter policies/procedures applicable to ASC as set forth in the BMS Provider manual.
Provider Exclusion from Participation in Federal Health Care Programs

The Office of Inspector General (OIG) has the authority to exclude from participation in Medicare, Medicaid, and other Federal health care programs those individuals or entities who have engaged in abuse or fraud. If an individual or entity is excluded from participation, this exclusion applies to all states and all Federal health care programs. Any provider excluded by the OIG is not permitted to participate in the West Virginia Medicaid or other Federal health care programs. The OIG publishes names of excluded individuals and entities. Access this list and other information relating to the exclusion program from the OIG Web site at: [http://www.oig.gov/](http://www.oig.gov/).

Providers are encouraged 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. It is the providers’ responsibility to ensure they do not bill or receive payment from WV Medicaid or any other federal health care program for services rendered or ordered by an individual on the exclusions list. Providers are advised to self-report any violation of the Federal Exclusion policy to the Office of Quality and Program Integrity (OQPI) by calling (304) 558-1700.

Enhanced Payment to Primary Care Providers

The Affordable Care Act (ACA) requires that Medicaid reimburse eligible primary care providers at parity with Medicare rates in calendar years 2013 and 2014 for certain evaluation and management and vaccination codes. Prior to receiving the enhanced rate, eligible physicians and advanced practice registered nurses (APRNs) must complete a Self-Attestation Form. Physician Assistants (PAs) automatically qualify if their supervising physician qualifies and self-attests.

To be eligible, a provider must first self-attest that they have a specialty designation of family medicine, general internal medicine, pediatric medicine, or one of the subspecialties outlined in the Provider’s Guide to Enhanced Primary Care Payments in West Virginia. Providers who fall under these specialties or subspecialties must then self-attest that:

- They are Board-certified in the specialty or related subspecialty to which they attest (please attach certification), or
- At least 60 percent of all the provider's billed codes, in the most recently completed calendar year, were billed for qualifying E&M and/or vaccine administration codes.
- Providers who have not participated in the Medicaid program for a full calendar year, they must attest that 60 percent of the Medicaid claims billed in the previous 30-day period were for E&M and/or vaccine administration codes that are eligible for the enhanced payment.

APRNs who are working under the direct supervision of, or in a collaborative relationship with, a qualifying provider, who are enrolled in WV Medicaid, and have their own WV Medicaid provider ID, must complete and return the self-attestation form if they wish to qualify.

The enhanced primary care rates are available to those qualifying providers who complete and submit the Self-Attestation Form. This form is available at: [www.wvmmis.com](http://www.wvmmis.com) or at [www.dhhr.wv.gov/bms/news/Pages/epc.aspx](http://www.dhhr.wv.gov/bms/news/Pages/epc.aspx). Qualifying providers will receive retroactive payments dating back to January 1, 2013 as long as the completed Self-Attestation Form is sent to BMS no later than December 31, 2013. A self-attestation form must be completed for 2013 and for 2014. Providers wishing to receive the enhanced rates for dates of service between January 1, 2014 and December 31, 2014 must submit the CY2014 Self-Attestation Form, which will be released later this year.
Enhanced Payment to Primary Care Providers (Continued)

Qualifying codes and their rates will be published on the BMS website. A notice will be posted on the BMS website to alert providers that they have been made available. Services provided in Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), as well as clinics and Health Departments, to the extent that they are reimbursed on an encounter or visit rate, are not eligible for enhanced payments, nor are services provided in nursing facilities that are reimbursed as part of the per diem rate.

Please see the BMS website for more details regarding the enhanced payments to primary care providers [http://www.dhhr.wv.gov/bms/news/Pages/epc.aspx](http://www.dhhr.wv.gov/bms/news/Pages/epc.aspx).

General Reminders:

- For Early Periodic Screening, Diagnosis and Treatment (EPSDT) services, providers must
  - Append -EP modifier to CPT/HCPCS code and
  - Enable EPSDT protocol in APS PA system
- Maternity Visits
  - Procedure code 99213 with modifier -TH (obstetrical treatment/services, prenatal or postpartum) must be billed for each individual prenatal or postpartum visit.
- Mastectomy or Related Reconstructive Procedures
  - Prior authorization is not required for individuals diagnosed with or with history of breast cancer.
  - The appropriate breast cancer diagnosis code must be documented on the CMS 1500 claim form for payment consideration.
Electronic Analysis of Implantable Pump

BMS’s Office of Facility Based and Residential Care has revised the reimbursement methodology for CPT procedure codes 62367, 62368, 62369 and 62372. These codes are not reimbursed in an outpatient hospital or any outpatient facility setting after 11/01/2012. Only one code may be billed at one time.

Statement Covers Period

Inpatient Hospital stays (including CAH) must indicate admit date through the discharge date in the Statement Covers Period (Block 6 on UB04 or Loop 2300*DTP*434 on an electronic institutional claim). Claim will deny if the Statement Covers Period is prior to the Admit Date.

Acute Care outpatient hospital services spanning June 30 through July 1 and September 30 through October 1 of any given year must be billed on separate claims. This does not pertain to CAHs, psych or rehab hospital claims.

Maternity Room and Board Revenue Codes

Molina has identified that some maternity claims are being denied due to a coding error. Upon researching the claims, they were billed without maternity room and board revenue codes or maternity ICD 9 code as the primary diagnosis. Although there may be some circumstances when you do not need a maternity revenue code, the claims will process more efficiently if you are billing the appropriate maternity room and board revenue code along with maternity diagnosis when applicable.

EHR Incentive Payments

Hospitals that are eligible for Electronic Health Records (EHR) incentive payments under both Medicare and Medicaid should select “Both Medicare and Medicaid” during the registration process, even if they initially plan to apply for an incentive under only one program. There is no reporting period for adopt/implement/upgrade. A hospital participating in the Medicaid EHR incentive program must meet all Medicaid requirements, including patient volume requirements.
Nerve Conduction Testing
Effective January 1, 2013, nerve conduction studies identified by CPT codes 95907-95913, are covered by WV Medicaid and require prior authorization regardless of place of service, e.g. inpatient, outpatient, or office setting. Physicians eligible for reimbursement for these codes are neurologist, neurosurgeon, anesthesiologist, orthopedist, physiatrist, and plastic surgeon. APS/WVMI will grant retrospective authorization until August 1, 2013. Contact APS regarding services already performed to obtain a prior authorization number with which to rebill denied claims.

Any provider who obtained a prior authorization for a nerve conduction study performed in an office setting, and subsequently received a claim denial, does not need to obtain a new authorization. These claims will be reprocessed by Molina.

Administration of Intranasal/Oral Vaccines
Effective January 1, 2013, BMS has opened the “add-on” code 90474 for the additional administration of intranasal/oral vaccines. This code is to be billed when other vaccines are being administered at the same time. The “add-on” code must be billed with 90473 or 90471. Claim check does not allow 90471 and 90473 to be reimbursed together.

Base of Tongue Reduction
CPT code 41530, Ablation of Tongue Base, for obstructive sleep apnea has been opened for coverage when conservative therapy has failed and the patient has a surgically correctible tongue obstruction lesion. The procedure is covered to otolaryngologists and otorhinolaryngologists, is restricted by diagnosis, and will only be reimbursed when an inpatient hospitalization stay for the procedure is approved by the Utilization Management Contractor. Effective date for coverage is 2/1/13.

Radiology Code Update
Effective January 1, 2012, radiology codes will allow payment for related radiopharmacological codes. Changes are as follows:

- 78226 and 78227 allow A9537 to pay;
- 78582, 78597 and 79598 allow A9540 and A9558 to pay;
- 78598 allows A9524, A5939, A9540, A9558, and A9567 to pay.

Denied claims will be reprocessed. Please refer to the “Drug Code List” under “HCPCS/Drug Codes” on the BMS webpage, www.dhhr.wv.gov/bms to see what CPT codes must be billed with each radiopharmacological code in order for payment to be considered.

Tobacco Cessation Counseling
Effective 2/1/13, WV Medicaid will cover two Tobacco Cessation Counseling services, CPT codes 99406 and 99407, in a calendar year when performed in the office by a physician or nurse practitioner.
**Procedure Code Updates**

**Balloon Sinus Dilation**
Procedure codes 31295, 31296 and 31297, Balloon Sinus Dilation, are covered procedures by WV Medicaid as of 01/01/2011 with prior approval from WVMI. The services will only be approved to be performed in a physician’s office, outpatient hospital, or ambulatory surgical setting by an Otologist, Otolaryngologist, or an Otorhinolaryngologist.

**Endovascular Revascularization**
Procedure codes 37220-37235, endovascular revascularization procedures, are covered to radiologists retroactive to 1/1/11 in addition to cardiologists, vascular surgeons, general surgeons, thoracic surgeons and cardio surgeons. Denied claims were reprocessed.

**Cerebrospinal Shunt**
Procedure Code 62252, reprogramming of programmable cerebrospinal shunt, is covered as a complete procedure to neurologists and neurosurgeons and is billable without modifiers effective 2/1/12. Prior to 8/1/12 components must be billed separately.

**Laboratory Services**
Effective 4/1/12 laboratory services 81211, 81212, 81214, 81216, and 81217 are covered to Independent Reference Labs.

**Claims Denied related to terminal illness of member**
Beginning 2/1/2013, all claims being denied because the service provided is related to the terminal illness of a member enrolled in the Hospice program will be denied using the HIPAA compliant Claim Adjustment Reason Code 97 – “The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.” The Hospice provider is responsible for services related to the member’s terminal illness.

This replaces the previous Claim Adjustment Reason Code 22 – “This care may be covered by another payer per coordination of benefits,” and Remittance Advice Remark Code MA04 – “Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.”

**Immune Globulin Services**
Effective 4/1/13, the following Immune Globulin services will no longer be covered as there are corresponding J codes that can be billed: 90281, 90283, 90291, 90371, 90384, 90385, 90389 and 90386. J codes can be found at [http://www.dhhr.wv.gov/bms/Pages/DrugCodeMDCDrugInformation.aspx](http://www.dhhr.wv.gov/bms/Pages/DrugCodeMDCDrugInformation.aspx).

**Cardiac and Brachytherapy Codes**
Effective March 1, 2013, cardiac service codes C1714, C1766, C1874, C1786, C1893 and C2629 and Brachytherapy codes C2616 and C2638 have been opened for outpatient coverage to acute care hospitals and CAHs. The codes require Prior Authorization and are restricted by diagnosis codes. They will be reimbursed by the hospital’s cost-to-charge ratio.

Retroactive to January 1, 2011, CPT codes 37225 and 37226 are billable by cardiologists. Denied claims will be reprocessed.

**Prior authorization no longer needed in an outpatient facility**
Beginning May 1, 2013 prior authorization is no longer needed when providing the following services in an outpatient facility: 11600, 11601, 11602, 11603, 11604, 11606, 11620, 11621, 11623, 11624, 11626, 11640, 11641, 11642, 11643, 11644, 11646 and 95873.

**Supernumerary teeth**
Effective 1/1/2012, the following codes are covered to supernumerary teeth; Procedure Codes: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2930, and D2920. Denied claims will be reprocessed.
Molina Medicaid Solutions Upgraded System

In July, 2012, Molina successfully implemented an upgrade to the claims processing system. There have been a few issues identified with this upgrade, some of which are identified below. Several of the issues were identified and corrected in an expeditious manner reducing any negative impacts to provider claims payment. If you question any claims processing, please contact Molina’s Provider Service Center at (888) 483-0793, Monday – Friday, 8:30 am to 5:00 pm.

Molina was denying claims incorrectly when the billed service required PAAS approval and was submitted on the claim. This issue was corrected for paper claims and electronic claims submitted in the 4010 format 9/8/2012. Molina is currently working on a resolution to claims submitted in the 5010 format and will update providers once this has occurred. If you believe your paper or 4010 format claim(s) were denied in error, please resubmit. We apologize for the inconvenience.

Molina was denying claims incorrectly when the billed service required NDC’s and the accurate NDC’s were billed on the claim. This issue is related to claims submitted in a 5010 format. Molina is currently working on a resolution to claims submitted that denied in error for this reason. Please check our web-portal provider alerts for updates on this issue. Again, we apologize for the inconvenience.

Web Portal Updates

Member Validation: 5010 Transactions

As part of the 5010 HIPAA transactions and effective May 1st, 2012, all submitted claims are matched on the Member’s Medicaid ID and Date of Birth as part of the Claim EDI validation. Claims are rejected if the Member Medicaid ID and Date of Birth do not match the information in the Molina claims processing system.
The Bureau for Medical Services (BMS) would like to remind providers that our Third Party Liability (TPL) contractor, Health Management Systems (HMS) is authorized to conduct Provider Recovery Services. When HMS identifies Medicaid payments associated with members who are also covered by Medicare or third party insurance, they initiate the Provider Disallowance Process.

HMS will send commercial disallowances reports quarterly and Medicare disallowances reports bi-monthly on behalf of Medicaid. Providers are expected to work the disallowances within 90 days as stated on the letters sent out by HMS. Please make every effort to respond to HMS within the 90 day timeframe at the phone number listed on the recoupment notice. A lack of response triggers automatic recoupment of Medicaid dollars. BMS is finding that once the recoupment has taken place, providers are submitting the necessary information and requesting a refund. This additional step results in a delay of provider payment and additional work for everyone. If an extension is needed, all provider contacts MUST still call HMS and request a 30 day extension, which is approved by BMS on a case by case basis.

To assist you in being proactive, a web portal is provided to facilitate responses to the disallowances, and most providers have already signed up for this. If you haven’t already signed up, you can reach HMS Provider Relations at 1-866-409-1185.

Recovery Audit

Section 6411(a) of the Affordable Care Act (ACA) expanded the Medicare Modernization Act of 2003 to Medicaid and required each state to begin implementation by January 1, 2012. The purpose of Section 6411(a) is to identify overpayments and underpayments to providers of Medicare and/or Medicaid services. The ACA required states to contract with a Recovery Audit Contractor (RAC) to coordinate recovery audit efforts and to reimburse the RAC through a contingency model.

The first step in the RAC process is for a policy review and data mining related to an identified policy issue. Improper payment scenarios will then be developed and approved by BMS. Once the scenarios are approved, either an automated or a complex review will be conducted.

Automated reviews are applied in scenarios where improper payments can be identified clearly and unambiguously. A letter will be sent to providers of payment error, related policy/rule/criteria/regulations and the amount of improper payment. Providers have the opportunity to respond to each determination and provide additional information. As applicable, HMS reviews any additional information and re-evaluates whether an improper payment exists based on WV Medicaid policy. After re-evaluation, result letters are sent to the provider which provides a detailed description of the final determinations, improper payment amount and option to appeal.

A complex review is required when analysis identifies a potential improper payment that cannot be automatically validated. Claims are flagged for further review and HMS determines what documentation is required to determine if an improper payment exists and/or the amount of the improper payment. Documentation is requested from the provider or appropriate party and reviewed to determine if an improper payment exists. After the review process is completed, letters are sent to providers with a detailed description of final determinations, improper payment amount and option to appeal.

Both the automated and the complex review are a 360 degree review, including clinical, regulatory and billing, conducted by a comprehensive panel of experts. The RAC must have staff experienced in performing reviews according to provider
types. Staff will include certified coders, registered nurses, auditors (CFE), dental hygienists/dentists, Medicaid billing experts, specialized therapy professionals and a review panel of over 1,000 physicians.

The RAC has a look back period of up to 36 months from the date of service for Medical, Dental, Behavioral Health and Durable Medical Equipment. Currently, prescription drugs, managed care organizations and crossover claims are excluded from the RAC.

If an automated or complex disallowance review letter is issued, providers have 30 days to respond. Generally, initial letter requests are due to HMS by the end of the 30th business day from receipt of the letter documented by standard postal delivery tracking methods. If a large amount of records are requested, this timeframe may be extended, per BMS approval. Failure to comply will result in the determination that the provider was improperly paid for all services under review for the requested dates of services, resulting in a pay hold being placed. If payments extend beyond 60 days, interest will be applied.

Providers may appeal any finding using the current appeal process as found in Chapter 880 (B) of the Medicaid Provider Manual. Providers are encouraged to call HMS’ Provider Services to discuss and resolve issues at 1-855-467-9520.
License Update Policy

Health care providers, who under the state plan and/or state statute are required to be licensed in West Virginia (WV) or the state in which they practice, must maintain and ensure that a current license is on file at all times with the West Virginia Bureau for Medical Services (BMS) Fiscal Agent, Molina. A provider’s participation in the WV Medicaid program may be terminated if Molina cannot verify the current status of a provider’s license.

Effective October 1, 2009, the Provider License Update Reminder Process is as follows:

- 60 days prior to the license expiration date, an initial reminder letter will be sent to the provider’s correspondence address indicating their current license expiration date. If an updated license is not received on or before the expiration date, the provider will be placed on pay hold.

- If a provider fails to submit a copy of their updated license 30 days after the expiration date, Molina will check listings from the licensing boards. If a provider’s license renewal date can be verified through the board listings, the pay hold will be removed. If Molina cannot verify an effective license renewal date via the board listing, the provider will remain on pay hold.

- A letter will be sent 30 days after the provider’s license expiration date to providers who have failed to submit their updated license. Molina will not verify license renewal through the licensing boards. The provider will remain on pay hold until the updated license is sent to Molina.

- 60 days after the license expiration date, Molina will make a telephone call to those providers that have not submitted an updated license. Providers who have failed to send an updated license to Molina will remain on pay hold.

- 90 days after the license expiration date, Molina will determine which providers have not complied and submitted an updated license. Providers who have not submitted an updated license will receive notification of intent to terminate if the updated license is not received within 30 days.

- If after 121 days from the initial license expiration date Molina has not received the provider’s updated license, the provider’s claims will be voided from Accounts Payable and the provider will be terminated from West Virginia Medicaid. A letter will be sent to the provider notifying them of the termination. Instructions on how to resubmit claims for payment for services rendered by the provider prior to the expiration date will be included in the letter. All other claims will remain voided and not payable. A listing of voided claims will accompany the letter.

- Providers may mail or fax a copy of any license renewal information or other credential/certification updates prior to expiration of the current license. Mailing address: Molina Provider Enrollment, PO Box 625, Charleston, WV 25322. Fax: Provider Enrollment 304-348-2763.

- All providers who have mailed or faxed their updated license will continue their Medicaid enrollment without interruption.
National Correct Coding Initiative (NCCI) – Frequently Asked Questions

Under the Affordable Care Act (ACA), WV Medicaid was mandated to implement NCCI. An FAQ is posted below with some commonly asked questions. The CMS website was used to formulate responses and can also be a useful source of reference for more information on NCCI editing.

Additional information can be obtained by accessing the following website: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html, as well as the Molina website: http://www.wvmmis.com.

What are NCCI Edits?
NCCI edits are defined as edits applied to services performed by the same provider for the same beneficiary on the same date of service. They consist of two types of edits:

NCCI procedure-to-procedure edits that define pairs of HCPCS/Current Procedural Terminology (CPT) codes that should not be reported together for a variety of reasons; and Medically Unlikely Edits (MUEs) or units-of-service edits that define for each HCPCS/CPT code the number of units of service beyond which the reported number of units of service is unlikely to be correct.

Are Medicare and Medicaid NCCI edits the same?
No, while the Medicare and Medicaid edits are the same in many instances, that may differ based on each State Medicaid agency's policies and procedures.

When did NCCI editing come about?
NCCI is a CMS program that consists of coding policies and edits. This program was originally implemented to ensure accurate coding and reporting of services by physicians. The NCCI procedure-to-procedure edits have been successfully used by the Medicare program since the mid-1990s with the adoption of MUE editing in 2007.

What are the five NCCI methodologies required for implementation in State Medicaid programs?
NCCI procedure to procedure edits for practitioner and ambulatory surgical center (ASC) services.
NCCI procedure to procedure edits for outpatient hospital services.
MUE units of service edits for practitioner and ASC services.
MUE units of service edits for outpatient hospital services.
MUE units of service edits for supplier claims for durable medical equipment.

Are Medicare crossover claims exempt from NCCI and MUE editing?
If the claim received contains a Medicare payment, it would be exempt from NCCI and MUE editing, as Medicaid would be considered the secondary carrier and the responsibility for editing would fall under Medicare’s processing rules.

When are NCCI edits updated?
Revisions to the NCCI edits are published quarterly in January, April, July and October of each year. States are mandated to implement all revisions as published by CMS. Providers should check the current list of edits when billing services that are not separately payable or exceed MUE limits. If billing does not comply with the NCCI edits in place at the time the claim line in question will be denied.

Am I allowed to bill an NCCI modifier so that I can be reimbursed for both procedures?
Program integrity will be monitoring the use of specific modifiers and randomly and routinely requesting records to support their use to ensure payments made are accurate and appropriate. Any payments made through improper use of modifiers solely to bypass NCCI edits or not meeting clinical requirements will be recovered.

What providers will be impacted by NCCI?
As NCCI edit mandates are continually updated all providers may ultimately be affected. It is imperative that each provider remain current on NCCI editing requirements which can be found at the following link: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html.

The implementation of NCCI edits does not prohibit BMS from implementing additional non-NCCI edits/limits based upon policy decisions. Providers are encouraged to remain diligent at reviewing the appropriate policy manuals on the BMS web site for current policy.
MCO Contacts
CareLink
888-348-2922

The Health Plan
888-613-8385

Unicare
800-782-0095

Vendor Contacts
APS
304-343-9663

WVMI
800-642-8686

HMS
304-342-1604

Claim Form Mailing Addresses
Please mail your claims to the appropriate
Post Office Box as indicated below; All PO Boxes:
All PO Boxes are at Charleston, WV 25337

Mailing Addresses

PO Box 3765
NCPDP UCF Pharmacy

PO Box 3767
UB-92

PO Box 3766
CMS-1500

PO Box 3768
ADA-2002

PO Box 3769
Charleston, WV 25337

Charleston, WV 25328-2254

Charleston, WV 25327-2002

Fax # 304-348-3380

Charleston, WV 25337-0625

Fax # 304-348-3380

Please send provider enrollment applications and provider enrollment changes to:

PO Box 625, Charleston, WV 25337

Molina Automated Voice Response System (AVRS) Prompt Tree

1-888-483-0793

Please make sure that you are utilizing the appropriate prompts when making your selection(s) on the AVRS system to ensure that you will be connected to the appropriate department for your inquiry. Once you have entered your provider number, the following prompts will be announced:

1. Accounts Payable Information
2. Eligibility Information
3. Claim Status Information
4. Provider Enrollment Department
5. Hysterectomy Sterilization Review
6. EDI Help Desk/Electronic Submission Inquiries
7. LTC Department
8. EHR Incentive
9. BHHF

Please send provider enrollment applications and provider enrollment changes to:

PO Box 625, Charleston, WV 25337

Claims and Application Information

As a participating provider and to expedite timely claims processing, please make sure claims are sent to the correct mailing address as indicated below:

• Facilities and Institutional Providers who bill on a UB04 Claims form – PO Box 3766, Charleston, WV 25337
• Medical Professionals billing on a CMS Claims form – PO Box 3767, Charleston, WV 25337
• Dental Professionals billing on ADA 2006 Claims form – PO Box 3768, Charleston, WV 25337
• Pharmacy Claim form NCPDP UCF – PO Box 3765, Charleston, WV 25337

Suggestions for Web Portal Improvements

We are looking for ways to improve the Web Portal. If you have any suggestions on how we can improve the portal to make it more ‘user friendly,’ please contact our EDI helpdesk at: edihelpdesk@molinahealthcare.com.