Welcome to the 2021 Fall Provider Workshop

Presentations will begin momentarilY
Fall 2021
Provider Virtual Workshops

November 2: 9:00am – Noon
November 3: 1:30pm – 3:30pm
November 4: 9:00am – Noon
November 9: 1:30pm – 3:30pm
November 10: 9:00am – Noon and 1:30pm – 3:30pm

Diana Bossie, Interim Director
Medicaid Management Information System
Due to the World Health Organization’s declaration of Coronavirus disease 2019 (COVID-19) as a pandemic, the West Virginia Department of Health and Human Resources (DHHR) is providing no-cost testing for all West Virginia residents, regardless of their insurance status.

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

- Vaccine codes pay at $0 (these are provided free of charge by the federal government).
- Effective for COVID-19 vaccines administered on or after March 15, 2021, the national average payment rate for physicians, hospitals, pharmacies, and many other immunizers will be $40 to administer each dose of a COVID-19 vaccine.
As of September 2021, 612,363 West Virginians received coverage (approximately 34% of West Virginia’s population).

- **Fee-For-Service (FFS), i.e., traditional/regular Medicaid:**
  - 118,422 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:**
  - 493,941 members are currently enrolled.
    - Includes eligible children, including those in foster care, adopted, or in Children with Serious Emotional Disorder Waiver (CSEDW); pregnant women; adult expansion; parents and caretaker relatives; and Supplemental Security Income (SSI) recipients.
Managed Care Update: Carved Out Services

What benefits are NOT included in the managed care plans?

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

*CSEDW is a managed care benefit.

**NEMT services are managed and paid for by the broker, ModivCare.
Managed Care Update: Contacts

Aetna Better Health of West Virginia (formerly CoventryCares)
Sarah White, Manager of Provider Relations
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 Medicaid and WVCHIP member online application portal, West Virginia inROADS, changed to the West Virginia People's Access to Help (WV PATH).

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

- The launch of WV PATH means all users will create a new username and password and will receive an email with instructions on how to create WV PATH credentials. If you need help using WV PATH, customer service is available at 1-844-451-3515.
Health Care

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

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

[Image of a woman and child]
Since August 2015, certain West Virginia Medicaid enrolled providers have had the opportunity to determine presumptive eligibility:

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

**Interested entities must:**

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

To begin enrollment or training, contact

**DHHRBMSPresumptiveEligibility@wv.gov**

For more information:

**https://dhhr.wv.gov/bms/Provider/HBPE/Pages/default.aspx**
WV PATH: Presumptive Eligibility Users

My Account

Dashboard

Applications

Profile

User Access

Organization

K: Start Presumptive Eligibility
L: Screen for Assistance
M: Programs & Services

N: Other Helpful Links
- West Virginia Breast and Cervical Screening Program (BCC)
- BMS Website
- Molina
- Your Guide to Medicaid
Electronic Visit Verification (EVV) Updates

EVV Update:

- HHAeXchange was awarded the EVV contract and went live on March 1, 2021.
- All waiver and personal care agencies must enroll their direct care workers in order to receive payment for services rendered.
- HHAeXchange’s aggregator platform supports West Virginia’s Open/Hybrid EVV Model by consolidating all visit data regardless of the EVV system being used to enable the State to manage provider compliance and ensure participants are receiving the right care at the right time.
- West Virginia providers will be able to submit confirmed visits and bill directly to the State through the free HHAeXchange Portal.

For more information:
https://dhhr.wv.gov/bms/Programs/WaiverPrograms/EVV/Pages/default.aspx
Coordinated Care Management was renamed Mountain Health Promise.

- Beginning March 1, 2020, Medicaid, residential and socially necessary services for children in foster care and post-adoptive children were transitioned from FFS to statewide managed care services in order to create a care management portfolio for vulnerable youth populations.

- A single managed care organization (MCO), Aetna Better Health of West Virginia, was selected to oversee this population and coordinate health and social services.
The Bureau for Medical Services (BMS) 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 Disorder (CSED), beginning March 1, 2020.

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

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

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

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

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

Enrollment with Medicaid and Medicare has been streamlined.

Newly opened provider types that can now enroll:
- Applied Behavior Analysis
- Case managers
- Direct-care workers
Effective January 4, 2021, West Virginia Medicaid began actively denying coverage of any controlled substance prescription which has been written by a prescriber without a current or valid Drug Enforcement Administration (DEA) number on file.

Please take this time to verify your provider file is updated properly.
Enrollment checklists:

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

### CRITERIA REQUIRED FOR ENROLLMENT

**Physician**

Provider Name: _______________________  
NPI Number: ___________________________

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

**Criteria for all specialties:**

- Current State License (per provider type)
- West Virginia Business License (If joining an established group, a business license is not required.)
Provider Enrollment Update (Cont.)
Electronic Funds Transfer (EFT) Initiative

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

- Providers are placed on **pay hold** if a bad EFT is returned until a corrected EFT is submitted.
- If you currently receive a paper check, please submit your EFT information immediately. Medicaid will stop sending paper checks in the future.

**Reminder:**

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

- The Centers for Medicare and Medicaid Services (CMS) conducts a medical record review of FFS payments to determine the appropriateness of the payment.
- Not every provider will be contacted to provide medical documentation; only those who provided services for the random sample of FFS claims will be selected. The random sample is pulled from all West Virginia Medicaid and WVCHIP FFS payments made in a fiscal year.
- Medical records are requested from the provider by the PERM Review Contractor for all FFS claims in the sample.

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

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

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

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

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

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

- The use of the UD modifier protects the 340B entity and the Medicaid program from rebate disputes regarding duplicate discounts.
- Entities are subject to audit by manufacturers or the federal government. Failure to comply with 340B requirements may make the 340B entity liable to manufacturers for refunds of discounts.
April 2021:
▪ Chapter 501 – *Aged and Disabled Waiver* (effective April 1, 2021)
▪ Chapter 512 – *Traumatic Brain Injury Waiver* (effective April 1, 2021)
▪ Chapter 513 – *Intellectual/Developmental Disabilities Waiver* (effective April 1, 2021)

May 2021:
▪ Chapter 519 – *Practitioner Services, Policy 519.5 – Cancer Screenings* (effective May 1, 2021)

July 2021:
▪ Chapter 502 – *Children with Serious Emotional Disorder Waiver* (effective July 1, 2021)
▪ Chapter 518 – *Pharmacy Services* (effective July 26, 2021)

Upcoming Changes:
▪ Chapter 510 – *Hospital Services*
▪ Chapter 300 – *Provider Participation Requirements*
Policy Update (Cont.)

West Virginia
Bureau for Medical Services

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WVDHHR > Bureau for Medical Services

Policy Manual

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

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

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

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

INDIVIDUAL CHAPTER SEARCH - TABLE OF CONTENTS
Chapter 100 - General Information
Chapter 280 - Definitions and Acronyms Effective November 1, 2016
Chapter 300 - Provider Participation Requirements Effective May 19, 2018
Chapter 400 - Member Eligibility Effective December 1, 2015
Chapter 501 - Aged & Disabled Waiver Effective January 1, 2019
Chapter 502 - Reserved
Chapter 503 - Licensed Behavioral Health Centers Effective July 15, 2018
Chapter 504 - Substance Use Disorder Services Revised July 1, 2019
Chapter 505 - Dental, Orthodontics, and Oral Health Services Effective December 1, 2016

https://dhhr.wv.gov/bms/Pages/Manuals.aspx
Non-Emergency Medical Transportation

West Virginia Medicaid has contracted with ModivCare to manage all non-ambulance, Non-Emergency Medical Transportation (NEMT).

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

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

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

NEMT Broker phone: 844-549-8353 | TTY: 866-288-3133
Form Locator 29: T1015 is required to be entered on line 1. Enter procedure code T1015, encounter code. Subsequent lines with specific American Dental Association (ADA) 5-character codes starting with the letter D should be entered for all specific services rendered.

Form Locator 31: Enter charges for each procedure code. ADA 5-character codes starting with the letter D must have a charge.

ADA 2012 Dental Billing Instructions for FQHCs and RHCs can be found at www.wvmmis.com/SitePages/Billing-Instructions.aspx.
Effective April 1, 2020, BMS reverted FQHC/RHC reimbursement back to the prior payment model when TPL is involved.

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

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

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

Modifier AD Medical Supervision by a Physician:

- Use to indicate payment for services when the anesthesiologist is involved in furnishing more than four procedures concurrently.
- Reimbursement: 3 base units with no additional time units
- The units field must always be “1” when this modifier is submitted.
Tubal Ligations

Professional and Facility Claims – Single Surgery:
- This includes CPT codes 58600, 58605, 58611, and 58615. All claims billed with these codes for single surgeries, including members that belong to an MCO, should be sent for processing to Gainwell Technologies for processing.

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

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

- Ambulance contracts have been updated to allow transport to alternate sites including urgent care centers during the Public Health Emergency (PHE).
Effective January 1, 2021, West Virginia Medicaid will follow Medicare’s guidance for using modifier KX on CMS 1500 claims and Condition Code 45 on UB04s to identify services for members who do not identify with their assigned birth gender.

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

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

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

A list of covered services can be found at
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 which affects his/her participation in the Medicaid program or reimbursement for a covered service.
- Must be requested by a provider.
- For full appeal details, see BMS Chapter 800A, General Administration.
- Billing agents working in conjunction with providers must follow the same time frames in requesting an appeal or document/desk reviews.
West Virginia Department of Human and Health Resources, Bureau for Medical Services (West Virginia Medicaid)
350 Capitol Street, Room 251
Charleston, WV 25301
304-558-1700
http://www.dhhr.wv.gov/bms

Medicaid Fee-for-Service
Gainwell Technology (formerly Molina/DXC) – Fiscal Agent:
https://www.wvmmis.com/default.aspx

KEPRO (formerly APS Healthcare) – Utilization Management (UM)
Contractor: http://wvaso.kepro.com

HMS – TPL Contractor: http://www.wvrecovery.com
Medicaid Managed Care (Mountain Health Trust)
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

FFS and Managed Care
ModivCare – NEMT Broker
Phone: 844-549-8353 TTY: 866-288-3133
www.modivcare.com
Contacts

Sarah Young, Deputy Commissioner
Diana Bossie, Interim MMIS Director
Jessica Dunlap, Interim MMIS Operations 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
FALL 2021
PROVIDER WORKSHOP
Presented by Kepro
Existing Kepro Scope of Work

- Health Homes
- Aged and Disabled Waiver (ADW), Intellectual/Developmental Disabilities Waiver (IDDW), and Traumatic Brain Injury Waiver (TBIW) Services
- Personal Care Services
- Nursing Home PAS Review
- Behavioral Health Services
- Substance Use Disorder (SUD)
- School-Based Health Services
- Medical Services
- WVCHIP (Fee-For-Service)
- BCF Socially Necessary Services
- Children with Serious Emotional Disturbance (CSEDW) Waiver Assessments
Websites/Direct Data Entry Portals

Medical Requests/WVCHIP Requests
• https://providerportal.kepro.com
Health Homes
• https://atrezzo.kepro.com
Behavioral Health
• https://careconnectionwv.kepro.com
Nursing Home PAS
• https://portal.kepro.com
Behavioral Health/BCF Socially Necessary
• https://careconnectionwv.kepro.com

Personal Care
• https://wvltc.kepro.com
Aged & Disabled Waiver
• https://wvltc.kepro.com
IDD Waiver
• https://wvltc.kepro.com
TBI Waiver
• https://portal.kepro.com
Members Served

- Fee-for-Service Medicaid and Behavioral Health Beneficiaries: 118,422 Currently Enrolled
- Aged & Disabled Waiver (ADW): 7,086 Active Members
- Personal Care: 5,832 Active Members
- IDD Waiver: 5,848 Active Members
- TBI Waiver: 80 Active members
- Health Homes: 9,812 Active Members
- NH PAS: 26,080 members reviewed for admission during FY2021
Kepro Provider Contact List

- All enrolled WV Medicaid providers are being asked to update their contact information. Please go to [https://survey.alchemer.com/s3/6268630/Kepro-Medical-Provider-Contact-Information-Update](https://survey.alchemer.com/s3/6268630/Kepro-Medical-Provider-Contact-Information-Update) and fill out the contact form.
- Please note this information is for Kepro only. We do not provide billing or managed care information.
  - This will not update provider enrollment information with Gainwell Technologies.
- This is to be sure that everyone involved in the prior authorization process stays up-to-date with announcements and trainings.
Traumatic Brain Injury Waiver - Atrezzo

• Access to Atrezzo for TBI Waiver Providers and Public Partnerships, LLC (PPL) was available on May 3, 2021.
• June 1, 2021 – TBI Waiver Case Managers submit Service Request.
• TBI Waiver Providers and/or PPL who are assigned to an applicant/member will be able to access and review applicant/member’s case records including:
  • The completed Pre-Admission Screening (PAS);
  • The applicable Rancho scale used to determine initial and reevaluation medical eligibility;
  • Medical eligibility determination letters;
  • Selection and Service Delivery Model (SDM).
• Training documents can be found on https://wvaso.kepro.com/wv-aso-traumatic-brain-injury-waiver.
IDD Waiver Adjustments to COVID-19

• Conducting periodic, frequent calls with providers and other IDDW stakeholders, such as advocacy groups.
• Conducting activities that were previously face-to-face remotely, such as member assessments and provider reviews.
• Providing individual technical assistance as needed/requested by providers.
In-Home Assessments for Waiver Services

• Due to the COVID-19 pandemic, in-home initial and annual reevaluations can be conducted either face-to-face or by phone.
• These options are available for IDDW, TBIW, ADW, and PCS.
• If there are special circumstances that make phone evaluation impossible for members with special needs to participate in phone evaluation, please let Kepro staff know when they contact the member to set up the appointment.
• Every effort will be made to accommodate members with special needs.
  • If an accommodation cannot be made, member services will continue until a face-to-face assessment can be safely conducted.
Waiver Services: Conflict Free Case Management

• Conflict Free Case Management is a federal requirement that promotes separation of Case Management and other services.
• Kepro’s field staff will be encouraging members who are currently at conflict to follow up with their ADW providers or Bureau of Senior Services (BoSS).
• There will be no interruption in the participant’s services.
• Participants will continue to have freedom of choice in selecting their provider agencies.
• Participant services will need to be provided by separate agencies.
• Participant services will still be determined with a Person-Centered Planning process.
• Implementation date is pending. Members will phase in corresponding to their anchor dates. Providers and members will receive further information prior to implementation.
• Additional information can be found here: https://dhhr.wv.gov/bms/Programs/WaiverPrograms/CFCM/Pages/default.aspx
COVID-19 Case Management – Medical and Behavioral Health

• Kepro has expanded its case management functions to assist fee-for-service Medicaid members and waiver members who have been tested for COVID-19.

• Information is received from the DHHR to alert BMS to fee-for-service members who have tested either positive or negative for COVID-19.

• All members with positive results are contacted to complete a questionnaire with a Kepro RN reviewer by utilizing the Social Determinants of Health Screening Tool and the COVID-19 Triage questionnaire to ascertain any essential needs and to provide education to the members and family.

• Total number of referrals to date: 43,409+
NH PAS – Atrezzo Benefits

• Online submissions auto-validate and all mandatory fields must be completed to submit.
  • Providers will be notified of incomplete fields before submission.
• Documentation can be uploaded by the provider to Atrezzo.
• Atrezzo system has an integrated communication system that allows for direct messaging between Kepro staff and Providers.
  • Please note: Direct messaging capabilities are not available if not submitted online.
• There is no wait time for customer service staff to key your request.
• NH PAS determinations can be printed directly from Atrezzo.
• Currently 90% of online submissions are auto-adjudicating.

Training documents and instructional videos can be found at https://wvaso.kepro.com/nursing-facility-program.
NH PAS Tips/Reminders for Faxed Submissions

• Form must be completed in its entirety.
  • With the implementation of Atrezzo two pages were added to the NH PAS form. The Supplemental Questions can be found at https://wvaso.kepro.com/nursing-facility-program.
• Referral from is to be completed, including person of contact with extensions. If facility/personal coversheet is available, please include.
  • This makes the point of contact easier to identify.
• PRINT legibly.
• Avoid “scribbling out” any information.
• Avoid writing over levels or information.
• Do not indicate a “range” of deficits, select only one level.
• Fax pages in order.
• Name of applicant needs to be on top of each page of PAS.
NH PAS Tips/Reminders for Faxed Submissions

• Timeline 2 business days for a completed Level I PAS.
  • This timeline begins when a completed PAS is received.
• Timeline 7-9 business days if Level II screening is required.
• Faxed resolutions are no longer automated. To receive determinations please call Kepro at 844-723-7811.
• Criteria for NH PAS can be found in the policy manual at dhhr.wv.gov/bms.
• Signature of applicant or a legal representative is required. The state of West Virginia does not recognize next of kin as a legal representative.
• A verbal consent may be obtained from applicant or legal representative.
  • Policy requires two professional witness (RN, LSW) signatures but due to COVID-19, only one professional witness signature is required at this time.
NH PAS Tips/Reminders for Faxed Submissions

• Any changes made to a PAS must be initialed and dated by the signing Physician.
• PAS is valid for 60 days from the Physician’s Assessment Date.
• Signing Physician must be MD or DO.
• History and physical and medication list should be included in documentation. This is not a requirement but does help the review process.
• If dementia/related condition is indicated, include any behaviors or temperaments.
Completing ADW and PC MNERs

- Form must be complete, legible, and no blank areas.
- The applicant/participant must sign and date. If unable, a Legal Representative must sign.
- Legal Representative, Guardian or Contact Area: MUST be completed if the applicant/participant has Alzheimer’s, dementia, or a related diagnosis. If not applicable, enter N/A.
- The Legal Representative signing the form must also be listed on the application.
- The request must be signed by the Physician (MD or DO), Nurse Practitioner, or Physician's Assistant. Original signature is required. (Signature is valid for 60 days).
- ICD-10 codes and descriptors should both be indicated (ADW).
- When the form indicates that the applicant has Alzheimer’s, brain multi-infarct, senile dementia or a related condition, it is required that the ICD-10 code be listed.
- Both terminal and Alzheimer's question must be completed.
Adult Dental Services – Reminders

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

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

• Coming in 2022, Kepro Medical Services will be transitioning platforms from WV C3 Provider Portal to Atrezzo New Generation (ANG) for prior authorization submissions.
• Transition to ANG will have no affect on the policies set in place by the Bureau for Medical Services.
• Communications regarding this transition will be sent out via email and posted on the Kepro website: https://wvaso.kepro.com/.
• Please be sure that you have completed the contact update to receive the most up-to-date information regarding this transition.
Tips for Successful Medical Authorizations

- All unlisted service codes require prior authorization.
- Please check Master Code List (MCL) or search by the CPT/HCPCS code when submitting via direct data entry (DDE) or by fax. There are some studies that do not require prior authorization.
  - The MCL can be found at [www.wvaso.kepro.com](http://www.wvaso.kepro.com) under Resources then Manuals and Reference Materials.
- Remember to attach or fax documentation to justify medical necessity.
  - Also, be sure to include written or electronic orders where applicable.
  - Dental: X-rays and attachments must contain the member’s name.
• Report conservative treatment history (e.g. physical therapy/duration; home exercise/duration) and NSAIDS history (duration/dosages).
  • These are the two most commonly omitted items that are required for review. If these interventions are contraindicated, specify the reasoning in medical justification.
• The ORP should select themselves as the referring provider when making a request either by fax or via DDE. The servicing provider is the facility/location of where the member will have the procedure(s)/service(s) performed.
Updating Provider Contact Information

- Sometimes the RN reviewers at Kepro must request additional information from providers.
- Having the incorrect contact information can result in cases being closed and delaying services to the member.
- Please update your contact information when submitting via DDE. This should include extensions or/and phone options.
Training and Technical Assistance

- We offer training via webinar, phone, and various materials to make submitting online for Prior Authorization an easier process for providers.
- Annual reviews/trainings are available to providers.
- Provider training is also offered for various provider groups.
- Each PowerPoint presentation from the provider trainings are posted to the [http://wvaso.kepro.com/](http://wvaso.kepro.com/) in the Manuals and Reference Materials section of our website.
Kepro Contact Information

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

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

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

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

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

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

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

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 Fax Numbers
• 844.633.8426 - Bariatric/Inpatient/Inpatient Rehab Under 21/Organ Transplants
• 844.633.8427 - Outpatient Surgery
• 844.633.8428 - Imaging/Radiology/Lab
• 844.633.8429 - Cardiac & Pulmonary Rehab/ DME/Orthotics & Prosthetics
• 844.633.8430 - Home Health/Hospice/Private Duty Nursing
• 844.633.8431 - Audiology/Speech/Chiropractic/Dental/Orthodontic/Podiatry/PT/OT/Vision
• 866.209.9632 - Modification Requests/EPSDT/Out of Network

Medical
• Toll Free: 800.346.8272
• General Email: wvmedicalservices@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

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• 844.633.8426 - Bariatric/Inpatient/Inpatient Rehab Under 21/Organ Transplants
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• 844.633.8430 - Home Health/Hospice/Private Duty Nursing
• 844.633.8431 - Audiology/Speech/Chiropractic/Dental/Orthodontic/Podiatry/PT/OT/Vision
• 866.209.9632 - Modification Requests/EPSDT/Out of Network

Medical
• Toll Free: 800.346.8272
• General Email: wvmedicalservices@kepro.com
Kepro Medical  
1007 Bullitt Street, Suite 200  
Charleston, WV 25301

1-800-346-8272 EXT. 7996  
MEDICAL SERVICES EMAIL: WVMEDICALSERVICES@KEPRO.COM  
MEDICAL FAX NUMBER: 1-866-209-9632

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Email</th>
<th>Ext.</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMILY PROCTOR</td>
<td>MEDICAL/IDDW/BH/SUD WAIVER DIRECTOR</td>
<td><a href="mailto:EBPROCTOR@KEPRO.COM">EBPROCTOR@KEPRO.COM</a></td>
<td>4455</td>
</tr>
<tr>
<td>KAREN WILKINSON</td>
<td>UM NURSE MANAGER</td>
<td><a href="mailto:KAREN.WILKINSON@KEPRO.COM">KAREN.WILKINSON@KEPRO.COM</a></td>
<td>4474</td>
</tr>
<tr>
<td>ALICIA PERRY</td>
<td>OFFICE MANAGER</td>
<td><a href="mailto:APERRY@KEPRO.COM">APERRY@KEPRO.COM</a></td>
<td>4452</td>
</tr>
<tr>
<td>SIERRA HALL</td>
<td>TRAINING SPECIALIST</td>
<td><a href="mailto:SIERRA.HALL@KEPRO.COM">SIERRA.HALL@KEPRO.COM</a></td>
<td>4454</td>
</tr>
<tr>
<td>JAMI PLANTIN</td>
<td>CUSTOMER SERVICE REP</td>
<td><a href="mailto:JAMI.PLANTIN@KEPRO.COM">JAMI.PLANTIN@KEPRO.COM</a></td>
<td>4502</td>
</tr>
<tr>
<td>JASPER SMITH</td>
<td>CUSTOMER SERVICE REP</td>
<td><a href="mailto:JASPER.SMITH@KEPRO.COM">JASPER.SMITH@KEPRO.COM</a></td>
<td>4490</td>
</tr>
<tr>
<td>JOHN JONES</td>
<td>CUSTOMER SERVICE REP</td>
<td><a href="mailto:JOJONES@KEPRO.COM">JOJONES@KEPRO.COM</a></td>
<td>4431</td>
</tr>
<tr>
<td>LAUREN PAYNE</td>
<td>CUSTOMER SERVICE REP</td>
<td><a href="mailto:LPAYNE@KEPRO.COM">LPAYNE@KEPRO.COM</a></td>
<td>4408</td>
</tr>
</tbody>
</table>

FOR SUBMITTING AUTHORIZATIONS: [https://providerportal.kepro.com/](https://providerportal.kepro.com/)  
WEBSITE FOR ORG MANAGERS TO REGISTER/ADD/MODIFY USERS: [https://c3wv.kepro.com/](https://c3wv.kepro.com/)
Questions?
2021 Fall Provider Workshop

WV BMS, WVCHIP, Gainwell Technologies

November 2021
Provider Enrollment- Direct Care Workers

• Gainwell Technologies continues to work with the Waiver Agencies to complete the enrollments of direct care workers related to the implementation of Electronic Visit Verification (EVV).

• Gainwell Technologies and HHAeXchange work together to share provider and member information required for the Electronic Visit Verification (EVV) process.
Provider Enrollment- Peer Support Recovery Specialists

- Beginning October 1, 2022, the Bureau for Medical Services (BMS) will require the West Virginia Certification Board for Addiction & Prevention Professionals (WVCBAPP) Peer Recovery certification as credentials for all existing and new PRSS to be reimbursed for PRSS services.

- BMS will terminate its own certification process on September 30, 2022 and only those individuals possessing the WVCBAPP’s Peer Recovery certification on October 1, 2022 will be eligible for reimbursement.

- These individuals will be required to enroll with Gainwell Technologies. GWT will work with the Licensed Behavioral Health Centers (LBHC) to complete the enrollment.

- BMS is providing a one year period to assist those individuals having a BMS certification to transition to the WVCBAPP certification.
Provider Enrollment- Home Health Attendants

• In preparation for inclusion in the Electronic Visit Verification system, Home Health Attendants will be required to obtain an individual NPI and enroll with Gainwell Technologies.
Provider Enrollment- Drug Free Moms and Babies (DFMB)

• The Drug Free Moms and Babies (DFMB) Project is a comprehensive and integrative medical and behavioral health program for pregnant and postpartum women.
• The project supports healthy baby outcomes by providing prevention, early intervention, addiction treatment, and recovery support services.
• There are currently 16 facilities participating in the program that will be enrolled with WV Medicaid.
COVID-19 Uninsured and Private Insured Claim Billing Options

• In response to the ongoing COVID-19 emergency, the West Virginia Department of Health and Human Resources has been authorized to provide limited coverage to patients that do not have Medicaid or WVCHIP coverage. This coverage is extended to patients that have no insurance at all (Uninsured) and patients that have private insurance and do not have WV Medicaid or WVCHIP coverage (Private Insured). This coverage provides limited services related to the testing and diagnosis of Coronavirus (COVID-19) and outpatient prescription drug treatment for the Uninsured.

• Claims for dates of services 06/08/2020 and after are required to be submitted with an application for COVID-19 Testing Coverage. Any claim that is submitted without an enrollment application will be placed in a pended status until the application is received. Once the enrollment application is received and reviewed, the claims will be released for processing. The enrollment application must be signed by the patient within 3 months of the date of service. Enrollment applications are located under the More Information on Coverage of Testing and Limited Treatment link on the BMS website: www.dhhr.wv.gov/bms.
COVID-19 Uninsured and Private Insured Claim Billing Options

• To be reimbursed for COVID-19 testing and/or treatment services for an Uninsured or Private Insured patient, providers may submit a paper claim, an electronic claim, or key the claim directly on the Health PAS-Online web portal (www.wvmmis.com). Claims being submitted for an Uninsured patient should be submitted with the generic COVID-19 Medicaid ID 24000000099. Claims being submitted for a Private Insured patient should be submitted with the generic COVID-19 Medicaid ID 24000000100. For detailed billing information, please refer to the WVCovid-19 Uninsured and Private Insured Claim Billing Options posting under Medicaid News on Health PAS Portal - www.wvmmis.com. Below is the address for paper claim submission:

  Gainwell Technologies
  ATTN: COVID-19 Testing
  PO BOX 2002
  Charleston, WV 25327-2002
Billing Updates

Podiatry Codes Update:
• Effective 04/01/2021, the following HCPCS/CPT codes have been approved for Podiatrist:
  – HCPCS codes: J1955, J3411, J3415, J3420, G0283
  – CPT codes: 96372, 97016, 97032 & 97150

FQHC Dental Billing:
• Effective 11/01/2020, all FQHC/RHC providers billing T1015 for dental services must bill charges on all lines or claim will deny

Pregnancy Termination:
• Effective 10-1-2020, the Physician Certification for Pregnancy Termination Form must be submitted with the claim for all pregnancy termination claims. In order to be reimbursed, one of the boxes must be checked, and if they are checked, the service can be claimed for match.
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 HealthPAS Grievance and Appeal Report cover page from the web portal or include a cover page with the below information.

Provider Name
National Provider Identifier (NPI)
Nature of Grievance/Appeal
Requested Action
Contact Information: Contact Name, Telephone Number, Email
Robotic Process Automation (RPA) – License Updates

Robotic process automation (RPA) is a form of business process automation technology that uses software robots to automate tasks performed by humans.

- Gainwell is working on a bot that will go out to state websites to confirm/validate license information.
- This initiative reduces manual and time-consuming processes.
Chatbots for Call Centers

- Gainwell is working on a chatbot initiative designed to answer FAQ’s on the portal.
- It can be used for both the Provider & Member portals.
- Questions can either be answered directly through the bot or with a link where the Provider/Member can do self-service within the portal.
Educational Webinars

- Gainwell provides monthly webinars to expand training, provide updates, and support for the provider community
- Enrollment – 1st Wednesday of the month
- Claims – 3rd Wednesday of the month
- Dates and times are also posted on our Gainwell website [www.wvmmis.com](http://www.wvmmis.com)
- Additional training can be conducted upon request
# Health PAS-OnLine - Emails, Phone Numbers, Mailing Addresses

<table>
<thead>
<tr>
<th>Department</th>
<th>Toll Free</th>
<th>Phone</th>
<th>Fax</th>
<th>Email</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>ZIP</th>
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</thead>
<tbody>
<tr>
<td>Provider Services</td>
<td>(888)483.0793</td>
<td>(304)348.3360</td>
<td></td>
<td><a href="mailto:wvmmis@dxc.com">wvmmis@dxc.com</a></td>
<td>PO Box 2002</td>
<td>Charleston</td>
<td>WV</td>
<td>25327-2002</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><a href="mailto:wvproviderfieldrepresentative@dxc.com">wvproviderfieldrepresentative@dxc.com</a></td>
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<tr>
<td>Provider Enrollment</td>
<td>(888)483.0793x4</td>
<td>(304)340.2763</td>
<td></td>
<td><a href="mailto:wvproviderenrollment@dxc.com">wvproviderenrollment@dxc.com</a></td>
<td>PO Box 625</td>
<td>Charleston</td>
<td>WV</td>
<td>25322-0625</td>
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<tr>
<td>EDI Helpdesk</td>
<td>(888)483.0793x6</td>
<td>(304)348.3380</td>
<td></td>
<td><a href="mailto:edihelpdesk@dxc.com">edihelpdesk@dxc.com</a></td>
<td>PO Box 625</td>
<td>Charleston</td>
<td>WV</td>
<td>25322-0625</td>
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<td>Long Term Care</td>
<td>(888)483.0793x7</td>
<td>(304)348.3380</td>
<td></td>
<td><a href="mailto:itc_v@dxc.com">itc_v@dxc.com</a></td>
<td>PO Box 3767</td>
<td>Charleston</td>
<td>WV</td>
<td>25337-3767</td>
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<tr>
<td>Member Services</td>
<td>(888)483.0797</td>
<td>(304)348.3365</td>
<td>(304)348.3380</td>
<td></td>
<td>PO Box 2002</td>
<td>Charleston</td>
<td>WV</td>
<td>25327-2002</td>
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<tr>
<td>Pharmacy Helpdesk</td>
<td>(888)483.0801</td>
<td>(304)348.3370</td>
<td>(304)348.3380</td>
<td></td>
<td>PO Box 3765</td>
<td>Charleston</td>
<td>WV</td>
<td>25327-3765</td>
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<tr>
<td>WVCHIP</td>
<td>(800)479.3310</td>
<td></td>
<td></td>
<td></td>
<td>PO Box 3732</td>
<td>Charleston</td>
<td>WV</td>
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<td>CMS 1500</td>
<td>PO Box 3767</td>
<td>Charleston</td>
<td>WV</td>
<td>25337-3767</td>
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<tr>
<td>UB 04</td>
<td>PO Box 3766</td>
<td>Charleston</td>
<td>WV</td>
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<tr>
<td>ADA 2006</td>
<td>PO Box 3768</td>
<td>Charleston</td>
<td>WV</td>
<td>25337-3768</td>
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<tr>
<td>NCPDB UCF</td>
<td>PO Box 3765</td>
<td>Charleston</td>
<td>WV</td>
<td>25377-3765</td>
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<tr>
<td>Reversal/Replacement</td>
<td>PO Box 3767</td>
<td>Charleston</td>
<td>WV</td>
<td>25337-3767</td>
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<tr>
<td>Timely Filing</td>
<td>PO Box 2002</td>
<td>Charleston</td>
<td>WV</td>
<td>25327-2002</td>
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<tr>
<td>Hysterectomy, Sterilization &amp;</td>
<td>PO Box 2254</td>
<td>Charleston</td>
<td>WV</td>
<td>25326-2254</td>
</tr>
<tr>
<td>Pregnancy Termination</td>
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2022 Spring Provider Workshops

Dates TBD
Questions
The content contained herein ("Confidential Information") are the confidential property of HHAeXchange and may not be copied or distributed outside the HHAeXchange organization without the express written consent of HHAeXchange. Distribution of this document or disclosure of any Confidential Information set forth herein to any party other than the intended recipient(s) of this presentation is expressly prohibited.
Agenda

- EVV Overview
- Provider EVV Compliance Reporting
- Billing Go-Live & FAQ
EVV Overview
The 21st Century CURES Act requires that the following data elements be captured and verified through **Electronic Visit Verification**:

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

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

➢ West Virginia providers have had access to HHAeXchange since **March 1st**, 2021
  ➢ Once Caregivers are enrolled with Gainwell, each provider is expected to begin confirming visits using EVV

➢ HHAeXchange is the **State Fee-for-Service EVV and Aggregation Vendor**

➢ The state has provided a free EVV solution through HHAeXchange and collect all visit data, regardless of the EVV system being used
  ➢ If your agency uses another EVV vendor, that is great! However, you are still **required** to send all visit data for services in scope to HHAeXchange for aggregation purposes
  ➢ Need to set up an EDI connection to send your data? Contact edisupport@hhaexchange.com
Provider EVV Compliance Reporting
How Can I Find My Compliance Percentage?

- Within the HHAeXchange portal there are a series of EVV reports available, which can be accessed at any time to check your agency’s compliance with the Cures Act.
The “Exception by Caregiver” report allows you to view each Caregiver’s exception rate.

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

- HHAeXchange EVV go-live was March 1, 2021

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

Billing through HHAeXchange ensures each claim submitted is backed up with visit evidence for services requiring EVV
- Visits confirmed manually can also be billed, as long as there is still electronically recorded proof that the visit occurred
Billing through HHAeXchange only applies to EVV required ADW, TBIW, IDDW, and PC services

- CSED agencies will continue billing services for this program directly to Aetna, but your visit data does need to be in HHAeXchange
- ADW, TBIW, IDDW, and PC services that do not require EVV should continue to be billed directly to Gainwell

Important things to remember when billing through HHAeXchange:
- Authorizations are required for billing
- Visits must pass pre-billing in order to be billed
- Caregiver NPI is required on claims generated through HHA
- Billed visits go through standard claim validations in the Billing Review module prior to submission to WV DHHR
- Re-billing is done in the HHAeXchange platform for all submissions (both EDI & HHA users)
Provider Resources

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

- Provider Information Center: [https://hhaexchange.com/wv/](https://hhaexchange.com/wv/)
  - Full FAQ, including Billing specific questions, found [here](https://hhaexchange.com/wv/)

- HHAeXchange Support
  - Phone: 866-983-4627
  - E-mail: wvsupport@hhaexchange.com
Questions?
Agenda

Overview

What is Mountain Health Trust?

Managed Care

Member Enrollment

Provider File

Outreach and Education
As of March 2021, there are approximately 604,060 WV residents covered by Medicaid and WV CHIP.
<table>
<thead>
<tr>
<th>Fee For Service</th>
<th>Managed Care</th>
<th>Enrollment Broker</th>
<th>Managed Care Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members who are <em>exempt</em> from managed care are served through a Fee-for-Service delivery system administered by Gainwell Technologies.</td>
<td>Members who are <em>eligible</em> for managed care are served through the Mountain Health Trust or WVCHIP programs.</td>
<td>MAXIMUS coordinates and enrolls all eligible managed care members into a managed care organization (MCO).</td>
<td>An MCO is often referred to as a health plan that coordinates the provision of health services through networks and case management.</td>
</tr>
</tbody>
</table>
Mountain Health Trust is the managed care program for West Virginia. With Mountain Health Trust, a member may choose a:

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

In addition, Mountain Health Trust is not:

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

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

Who must Enroll

- Most children, parents and caretakers
- SSI recipients (Disabled)
- Medicaid expansion (Adults)
- Pregnant women
- WVCHIP

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

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

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

Providers may verify Medicaid eligibility and enrollment for Fee-For-Service and MCO members via the Gainwell Provider Portal.
Member Enrollment – Process

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

A member enrolls into an MCO of their choice before cutoff 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 cutoff 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.
MAXIMUS receives a weekly provider file from each MCO that contains all providers currently in their health plan network. The provider file contains: provider name, address, phone number, group or clinic name, provider type, and specialty. The provider file received from each MCO is compiled into a master file that is used on the www.mountainhealthtrust.com website and by our call center agents to validate provider information.

If there is an error in your provider information, you may contact our call center at 1-800-449-8466 and we will forward the correction to the appropriate MCO.
• Effective July 1, 2021 (August 1 for FQHC/RHC providers), THP has implemented a Social Determinants of Health Program (SDOH) that rewards providers for submitting Z-code diagnoses as part of their claims submission.

• Providers submitting a covered Evaluation and Management (E/M) code, along with a qualifying Z-code diagnosis (Z55-Z65), shall receive an enhanced reimbursement on their claim.

• This information will be used by THP to help build our members’ care plans and conduct more targeted intervention to help find resources for them in their communities.
Early Periodic Screening, Diagnostic Treatment (EPSDT)

- Exams at a minimum must include, but are not limited to the following:
  - Comprehensive health & developmental history (both physical & mental health development)
  - Unclothed physical exam
  - Lab tests (with blood lead screening appropriate for age & risk factors)

- Vision testing
- Appropriate immunizations
- Hearing testing
- Dental services
- Behavioral health screening
- Health education (including anticipatory guidance)

Please note: Providers should utilize the EP modifier when billing for EPSDT services. Example of CPT Codes: 96110 & 96127
Practice management consultants will be educating providers to capture:

- Annual dental visit
- Breast cancer screening
- Cervical cancer screening
- Controlling high blood pressure
- Comprehensive diabetes care
- Blood sugar control
- Diabetic eye exam
- Kidney disease monitoring
WV Children’s Health Insurance Program

- Effective January 1, 2022, all behavioral health providers rendering services to WVCHIP shall be required to be credentialed with THP at the individual level. This will mirror the process that is required for the provider enrollment component completed by Gainwell.

- After January 1, claims submitted with a rendering provider that has not completed credentialing will be denied.

- If you are unsure if you or a provider within your organization is credentialed at the individual practitioner level, your Practice Management Consultant can assist with reviewing to help prevent any payment denials.
Examples of activities which are NOT appropriate for Targeted Case Management billing include the following:

- Quality and completeness reviews of member records
- Preparation of urine drug samples to be sent to the lab
- Reviews of UDS results in Medication Assisted Treatment programs
- Billing that duplicates TCM billing by another staff person in the same time frame performing different TCM activities
- Billing by different case managers on the same member (exceptions can be made for unusual circumstances)
- Preparation of group therapy workbooks
- Calls from front desk staff as appointment reminders
Dual-Eligible Special Needs Population (D-SNP)

- **D-SNP is a THP Medicare Advantage plan**
  - Members have SecureCare HMO primary
  - WV or OH State Medicaid Secondary
  - **Member has $0 responsibility**

- Annual training is required by Centers for Medicare and Medicaid (CMS) for providers serving the D-NSP population

- Training materials and attestation are currently available at: healthplan.org. Click “For Providers,” “Medicare & Medicaid” “Dual Eligible Special Needs Plan (D-SNP).” Information regarding the D-SNP program and the attestation can be found there or by contacting your practice management consultant.
Cultural Competency Requirement

- CMS requires ALL providers complete cultural competency training
- THP tracks network providers to ensure compliance and it is noted in THP's provider directories
- Click “Secure Login” on THP’s website to access training materials and an attestation form under Resource Library
- Attestation from another MCO or proof of attendance at a seminar is acceptable
Encounter Data Validation (EDV)

• Qlarant, the External Quality Review Organization for WV Medicaid, has been contracted to complete Encounter Data Validation (EDV) for accuracy and completeness.

• To complete this exercise, Qlarant will be contacting providers directly for medical records to help with their review.

• Providers should submit all requested information to Qlarant to assist.
Appeal Process

If a member believes his or her benefits were unfairly denied, reduced, delayed or stopped, the member has the right to file an appeal with The Health Plan. The member also have the right to appeal any adverse decision.

• To file an appeal, call The Health Plan at 1.888.613.8385.
• To file an appeal in writing, fax it to The Health Plan at 1.888.450.6025, or mail it to 1110 Main Street Wheeling, WV 26003.

If the member calls and gives his or her appeal over the phone, The Health Plan will acknowledge the appeal in a letter.

Members must file an appeal within 60 calendar days from the date on the notice of action from The Health Plan. Members are entitled to one level of appeal, prior to requesting a State Fair Hearing.

The Health Plan will issue a decision on the member’s appeal within 30 days.
Provider accessibility standards for PCPs include

PCPs available 24/7 with appropriate call coverage and after-hours answering service for urgent/emergent conditions.

<table>
<thead>
<tr>
<th>Service</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine (other than preventive)</td>
<td>Within 21 calendar days</td>
</tr>
<tr>
<td>care (exemptions permitted when PCP capacity is temporarily limited)</td>
<td></td>
</tr>
<tr>
<td>Adult urgent care</td>
<td>Within 48 hours</td>
</tr>
<tr>
<td>Pediatric urgent care</td>
<td>Seen same day</td>
</tr>
</tbody>
</table>
## Provider accessibility standards for PCPs

<table>
<thead>
<tr>
<th>Service</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergent cases</td>
<td>Seen immediately, refer to an emergency facility or call 911</td>
</tr>
<tr>
<td>Physical exams</td>
<td>Within 180 calendar days</td>
</tr>
<tr>
<td>Preventive/EPSDT</td>
<td>Scheduled per EPSDT guidelines and the EPSDT Periodicity Schedule within 30 days</td>
</tr>
<tr>
<td>In office wait time</td>
<td>Within one hour of appointment time</td>
</tr>
<tr>
<td>Provider accessibility standards for Specialists</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>--</td>
</tr>
<tr>
<td>New or established patients</td>
<td>Within 30 calendar days</td>
</tr>
<tr>
<td>In office wait time</td>
<td>Within one hour of appointment time</td>
</tr>
</tbody>
</table>
Access to Care - Prenatal

<table>
<thead>
<tr>
<th>Provider accessibility standards for Prenatal Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial prenatal visit</strong></td>
</tr>
<tr>
<td><strong>First and second trimester visits</strong></td>
</tr>
<tr>
<td><strong>Third trimester visit</strong></td>
</tr>
<tr>
<td><strong>High risk pregnancy</strong></td>
</tr>
</tbody>
</table>
Overpayments

As a reminder, providers are required to follow the guidelines within the provider manual. The provider manual is located on our website at https://www.healthplan.org/providers/resources/provider-manual

- The Health Plan is responsible for the recovery of all overpayments, including those due to fraud, waste, and abuse.
- Providers are required to return the full amount of the overpayment within 60 calendar days of identification
- THP may recover the overpayments up to 24 months from the date of service.
  - This recovery will be administered through the claims system by offsetting the overpayment against future claims payments.
Front End Editing Modification

The Health Plan is making modifications to our front-end editing known as EDIF ECS for electronic, paper claims, and denials for incomplete billing

Example: admission dates missing

To ensure your practice does not receive denials, follow the Gainwell companion guide as we are setting up additional edits on the front end that will reject claims

Paper claims will begin going through the EDIF ECS logic as well.

We encourage you to make sure your system is set up to follow Gainwell guidelines.
The Health Plan is pleased to announce an enhancement to our provider portal. This will give providers a heightened view in the following areas:

- Prior Authorizations
- Member Rosters
- Quality Measures/Care Gaps
- Document Upload
- Admission, Discharge, Transfer Info. (Medicaid Members Only)
- Case Management
- Care Coordination
The Health Plan is pleased to announce an enhancement to our provider portal.

This will give providers a heightened view in the following areas:

- Inpatient admission notifications with document upload for level of care assessment and concurrent review
- Status updates on inpatient admissions
- Ability to communicate with UM staff within an authorization request
Provider Portal Registration

Register at **myplan.healthplan.org**

- View announcements and educational presentations
- View claim status
- Submit professional claims online
- Verify member eligibility
- Print payment vouchers
- Request prior authorizations
- View prior authorization status
Provider Information

To ensure you are correctly listed in THP’s directories, visit findadoc.healthplan.org

- Go to “Find a Provider”
- Click “Search Online” button
- Enter last name
- Select “All” providers and submit
- Double click on appropriate underlined name
- Click new button “Verify/Update Practice Info”
- Option to “Confirm No Changes” or update erroneous information
  - You will need the provider’s tax ID and NPI numbers
  - Submitted directly to provider support department to update THP system
THP primarily communicates via email blast

- Core Communication – a brief communication sent every 2 weeks that highlights trends or issues we are identifying within our provider community
- THP ProviderFocus – a quarterly newsletter sent via email

You may register to receive these communications at providersupport@healthplan.org

- Contact Customer Service at 1.877.847.7901 to request paper copies
- View the latest edition and past newsletter editions on our website at healthplan.org
Contact Information

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

THP Provider Portal
myplan.healthplan.org

THP Corporate Website
healthplan.org

Prior Authorization
1.740.695.5297 (Fax)
Thank You!
Joining the UniCare network

• Enroll your NPI with Gainwell Technologies prior to reaching out to UniCare.
• All new network contracts for UniCare require a current W-9.
• Send a completed Provider Application Form with updated Council for Affordable Quality Healthcare (CAQH) information when adding a new provider to UniCare.
• Your effective date will be the credentialing approval date and cannot be backdated with UniCare.
Electronic funds transfer (EFT) updates

• As of November 1, 2021, EnrollSafe at enrollsafe.payeehub.org will replace CAQH EnrollHub for providers to enroll or make changes to their EFT:
  o Current EFT providers will be automatically transferred, and no action needed unless they need to make changes.
• CAQH EnrollHub will be phased out by January 2022.
Billing updates and reminders

- Substance use disorder (SUD) residential services:
  - When billing for SUD residential services, you must use a place of service (POS) 55.
- Peer recovery H0038:
  - Effective May 1, 2021, an authorization is required after 60 units have been used each month, which consists of a 28 rolling day period.
  - CPT® codes:
    - H0004 HO
    - H0004 HOHQ
  - UniCare’s member benefit year:
    - July 1 to June 30
- Telehealth billing requirements:
  - POS 02
  - Modifier GT
Billing updates and reminders (cont.)

• Vaccinations:
  o Do not include the National Drug Code (NDC) when billing for vaccines to prevent denials and delayed payment.

• Member balance billing reminder:
  o 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 two links provided below:
    ▪ [https://provider.unicare.com](https://provider.unicare.com) > Resources > Provider Manuals, Policies & Guidelines
Billing updates and reminders (cont.)

• Newborns can be billed under the mother’s UniCare ID for 60 days.
• Timely filing limit:
  o Original claim submission — 180 days from date of service
  o Corrected claim submission — 180 days from the original *Explanation of Benefits (EOB)* date
• All eligibility should be verified on Availity* and/or Gainwell portals prior to care being rendered.
• All licensed behavioral health center (LBHC) providers must be credentialed with UniCare for WVCHIP.
Member cards

Note: The member’s plan will be designated on the front of the card.
Claim dispute tool

- Access the *Claim Dispute Tool* through the Availity Portal at [https://www.availity.com](https://www.availity.com).
- Access the claim through the *Claim Status* search page.
- Select the claim you want to dispute by choosing **Dispute Claim**.
- Letters will be sent with final determination when the dispute is closed.
Online authorization requests

- The Interactive Care Reviewer (ICR) is a real-time solution that improves efficiency and timeliness of the prior authorization process.
- Through ICR, you are able to:
  - View determination letters for **medical prior authorization requests** (not available for pharmacy).
  - Save ordering and servicing provider information to your favorites.
  - Search historic prior authorizations and other related information and documentation.
Utilization management appeal process

- Appeals are accepted for up to 60 days after a denial is issued.
- A physician clinical reviewer of the same or similar specialty who was not involved in any previous level of review or decision-making reviews the provider appeal.
- The physician specialist may not be the subordinate of any person involved in the initial determination.
- The physician specialist reviews the case and contacts the provider as necessary to discuss appropriate alternatives, render a decision, and document a decision.
Utilization review resources

- Review turnaround times:
  - General prior authorization: seven days
  - Requests submitted via ICR: two business days; may be extended to seven calendar days if more information is required
  - Urgent prior authorization: two business days or three calendar days, whichever is most stringent
  - Current inpatient admission authorization: two business days or three calendar days, whichever is most stringent
  - Routine appeals: 30 days
  - Expedited appeals: three calendar days
Utilization review resources (cont.)

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

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

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

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

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

• Peer-to-peer line:
  o Phone: 866-902-4628
Provider chat feature

Access provider services digitally through *Payer Spaces* on Availity to chat about:
Any provider inquiry related to any member type for any line of business at an established time.
Provider chat screen flow

- Log into Availity and select the market.
- Select **Payer Spaces** and select plan.
- In **Payer Spaces**, select **Chat with Payer** option.
Provider chat screen flow (cont.)

- Pre-chat form provides additional information needed to route the chat.
Provider chat screen flow (cont.)

- Complete the pre-chat form.
- Select **Continue**.
- **Provider Service Assist** chat window displays.
Availity reminders

Availity offers multiple features to help decrease your need to reach out to our Customer Care Center.

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

<table>
<thead>
<tr>
<th>Type of appointment</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency examinations</td>
<td>Immediate access during office hours</td>
</tr>
<tr>
<td>Urgent (sick) examinations</td>
<td>Within 28 hours of request</td>
</tr>
<tr>
<td>Nonurgent (sick) examinations</td>
<td>Within 72 hours of request</td>
</tr>
<tr>
<td>Nonurgent routine examinations</td>
<td>Within 21 days of request</td>
</tr>
<tr>
<td>Specialty referrals</td>
<td>Within three weeks for routine referrals; within 48 hours for urgent referrals</td>
</tr>
</tbody>
</table>

More details are located in our policy and guidelines:  
# Appointment availability requirements (cont.)

<table>
<thead>
<tr>
<th>Type of appointment</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>First trimester (use the <em>Pregnancy Notification Report</em> found on provider website)</td>
<td>Within 14 calendar days of determination of pregnancy</td>
</tr>
<tr>
<td>Second trimester (use the <em>Pregnancy Assessment Form Second Trimester — Reassessment</em> found on provider website)</td>
<td>Within seven calendar days of request</td>
</tr>
<tr>
<td>Third trimester (use the <em>Pregnancy Assessment Form Third Trimester — Reassessment</em> found on provider website)</td>
<td>Within three business days of request</td>
</tr>
<tr>
<td>High-risk pregnancy</td>
<td>Within three business days of identification or immediately if an emergency exists</td>
</tr>
<tr>
<td>Postpartum exam (use the <em>Postpartum Checkup</em> found on provider website)</td>
<td>1 to 12 weeks after delivery of appointment standard</td>
</tr>
</tbody>
</table>
After-hours care

- Members will have access to quality, comprehensive healthcare services 24/7.
- Members can receive help with emergency calls.
- The system is in place to ensure that members can reach the PCP or an on-call provider.
- Members can also call the 24/7 NurseLine.

Cultural competency training

- **Cultural Competency and Patient Engagement Training** includes:
  - Enhanced content regarding culture including language and the impact on healthcare.
  - A cultural competency continuum that can help providers assess their level of cultural competency.
  - Guidance on working effectively with interpreters.
  - Comprehensive content on serving patients with disabilities.
Cultural competency training (cont.)

• *Caring for Diverse Populations Toolkit* includes:
  o Comprehensive information on working with diverse patients and effectively supporting culture, language, and disabilities in healthcare delivery.
  o Tools and resources to help mitigate barriers including materials that can be printed and made available for patients in your office.
  o Guidance on regulations and standards for cultural and linguistic services.

• In addition, providers can access [https://mydiversepatients.com](https://mydiversepatients.com) for easy and free access to tools and resources that are accessible from any smartphone, tablet, or desktop. Providers will find continuing medical education courses.
Looking ahead

- Contract repapering project
- Electronic provider enrollment
Territory map

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

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

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

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

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

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

As of October 2021
Thank you
Cynthia Harper – WVU, CAMC, Cabell Huntington, Marshall Health
304-348-2932
HarperC1@aetna.com

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

Key

Email: ABH_WV_ProviderRelations@aetna.com

Open 304-348-2936

Lisa Sentich 304-234-3486
SentichL@aetna.com

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

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

Layla Sawyers 304-348-2013
SawyersL@aetna.com
Provider Portal Updates

• Moved to Availity platform March 1, 2021

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

• Targeted for Q3 2021
  ✓ Remittance viewer
  ✓ Panel Roster
  ✓ Reconsideration submission

• Register for access at https://availity.com/provider-portal-registration
Mountain Health Promise

• ABH of WV currently has 25,903 members enrolled in the Mountain Health Promise program

• Care Management works closely with enrollees and families to coordinate care and identify gaps

• Cross Functional teams at the health plan work with providers to improve outcomes and support our members and their families.
Children with Serious Emotional Disorder Waiver

• ABH of WV currently has 251 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.
HEDIS Incentive Update

- Effective 3/30/21, well child incentive is now offered for exams completed on targeted ABH of WV children ages 12-17 who are 12 months or more past their last exam date.

- For each targeted member that receives a well child exam, you will receive $25.00.

- This is due to a significant change to the NCQA well child measures for HEDIS.
Claims Editing Updates

• Effective 5/25/21

✓ DNA Based Colorectal Cancer Screening Tests – once per 3 years, for routine purposes only for adult members
✓ Planned Cesarean Delivery – should not be performed before the gestational age of 39 weeks in the absence of other indications for early delivery
✓ COVID-19 Testing – only one type of test per day within the same category.
Prior Authorization Changes

- H0038 – (Peer Recovery Support Services) authorization required after 80 units per month effective 7/1/21
Trauma Informed Care

- Educational resources available on the ABH of WV website
  - Introduction to Trauma-Informed Care video (36 minutes)
  - Trauma-Informed Care in Foster care video (31 minutes)
  - One-page educational materials on a variety of topics
Training in Adoption Competency

• Facilitated by the National Adoption Competency Mental Health Training Initiative

• Offers CEUs and, upon completion, addition to the National Directory of NTI Trained Professionals

• Details available at https://adoptionsupport.org/nti/access/access-for-individuals
Provider Webinars

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

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

• RSVP to your Provider Relations Representative.
Thank you!
West Virginia BMS

NEMT
Non-Emergency Medical Transportation
Agenda

- What does ModivCare do?
- How to contact ModivCare
- Who can request transportation?
- “Travel (Distance, Trip Limits and Authorization)”
- “Notification, Advance Notice and Same Day Requests”
- Standard Trip Information
- Levels of Service Provided
- Mobility Assessment
- Durable Medical Equipment

- Covered Services
- Return Ride Home
- Service Concerns & Escalation Process
- Facility Liaison
- Exceptions Facility Department
- How to Request Standing Order Services
- TripCare
- Outreach
- Questions
- Contact Information
What does ModivCare do?

• Coordinates requests for non-emergency medical transportation (NEMT) for eligible members

• Schedules & routes NEMT for members based on their medical and mobility needs

• Contracts with, and pays, local transportation companies to perform the non-emergency medical transportation

Hours of operation for routine reservations:

• Monday through Friday, 7am to 6pm (EST)

• Routine reservations will not be accepted on national holidays

Calls for trips for urgent/same-day appointments/facility discharges and Ride Assist: 1-884-549-8354

• 24/7 – 365 days

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

Contact Us

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

- Member 18 yr. (or under 18 if they are emancipated).
- Parent/Legal Guardian
- Authorized Representative of Member
- Health Plan Representative
- Medical Provider
Travel permitted in the state of West Virginia

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

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

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

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

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

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

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

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

A member is required to provide their own:

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

Additional Passengers

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

Member return home options:

- Schedule a set pickup time for the return home from the medical facility
- Schedule the return home as a “Will Call” and the return time is left open until the member calls us to advise they are ready to go home
  - If scheduled as a “Will Call” Provider has up to 1 hours from the time of the call to pick up Member.
Service Concerns & Escalation Process

- ModivCare’s Ride Assist Number: 844-549-8354
  - The Customer Service Representative (CSR) will attempt to resolve the issue in real-time whenever possible.
  - If the driver is running late, they will notify ModivCare and we will work with the member and Healthcare Facility to see if member can still be seen at a later time.
  - The CSR will document any complaint for further research and resolution.

- Contact the appropriate insurance plan from the list ModivCare distributes to facilities as soon as there is a transportation issue with member i.e. late drop off, late pick up, no show, safety issues, etc.

- Inform ModivCare or encourage the member to inform ModivCare 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. several missed appointments, member no longer attends facility, etc.

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

ModivCare Facility/Provider Liaison:

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

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

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

• Updates facilities and members on ModivCare processes.

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

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

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

Modivcare Exceptions Facility Department:

• Assists facilities (i.e. nursing homes, dialysis, etc. with standing orders) in arranging and coordinating their clients’/members’ transportation needs via fax or email.

• Coordinates and schedules transportation requests for dialysis clients received by fax or email.

• Screens requests for appropriate level of care needed and service covered per insurance contracts.

• Provides consistent and timely communication with all facilities and members regarding transportation issues.

• Provides superior customer service as evidenced by handling all facility-related phone calls.

• Maintains and updates addresses, phone numbers, and fax numbers as needed.

• Coordinates recertifications and attendance reports in a timely fashion and communicates all information with the health care plan.
How to Request Standing Order Services

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

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

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

For further inquiries related to outreach:
• Standing orders
• TripCare: request access, training etc.
• In-service visit
• Please contact your Outreach Coordinator or Facility Liaison for further information. (Please see last slide)
Contact Information

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

Title: Exceptions/Facilities Manager
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Please do not give this contact information directly to members.
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