

WV BUREAU FOR MEDICAL SERVICES

2015 SPRING PROVIDER WORKSHOPS

Sarah Young, BMS Acting Deputy Commissioner, Policy Coordination
Tanya Cyrus, RN, BMS Director of Policy Administrative Services
Kristen Childress, DHHR RAPIDS Outreach Communication Coordinator

April 13 - Martinsburg, WV
April 14 – Wheeling, WV
April 15 – Morgantown, WV
April 20 – Roanoke, WV
April 21 – Huntington, WV
April 22 – Beckley, WV
April 23 – South Charleston, WV



WEST VIRGINIA
Department of
Health & Human Resources
BUREAU FOR MEDICAL SERVICES

Medicaid Expansion Update

As of April 6, 2015, approximately 155,570 have enrolled in WV Medicaid as a result of the expansion:

- 43% are between 19 and 34 years of age
- 35% are between 35 and 50 years of age
- 20% are between 51 and 64 years of age
- Less than 2% fall outside of these age ranges

Approximately 53% of the new enrollees are female and 47% are male.

Approximately 28% (504,014) of West Virginia's population is now covered by Medicaid.

- About 41% of these individuals are receiving services through Mountain Health Trust, the State's Managed Care Program.

Medicaid Managed Care Update

Effective July 1, 2015

- Medicaid Expansion members will be transitioned to MCOs
- Current MCO members will have behavioral health benefits rolled into MCO

Contact MCOs for more information:

- **CoventryCares of West Virginia**

Michelle Coon, Director of Operations/Site Manager (Phone: 304-348-2017; Email: mcoon@aetna.com)

- **Health Plan of the Upper Ohio Valley**

Christy Donohue, Director, Medicaid (Phone: 304-720-4923; Email: cdonohue@healthplan.org)

Jennifer Johnson, Manager Medicaid (Phone: 740-695-7850; Email: JJohnson@healthplan.org)

- **UniCare Health Plan of WV**

Anthony Duncan, Director Network Relations (Phone: 304-347-2481; Email: anthony.duncan@anthem.com);

Terri Roush, Manager, Network Relations (Email: terri.roush@anthem.com);

Carrie Blankenship, Network Education Representative (Phone: 304 533 4086; Email: carrie.blankenship@anthem.com)

- **West Virginia Family Health**

Donna Sands, Director of Operations/Controller (Phone: 304-424-7661; Email: donna.sands@highmark.com)

Bariatric Surgery Policy Updated

- Effective April 1, 2015, BMS will cover certain laparoscopic bariatric surgery
- Surgeon must be Board Certified
- Facility must be a Center of Excellence

Home and Community Based Waivers

- Draft Applications for renewal by CMS on BMS website
 - ADW and TBI – Public comment period ends April 17, 2015
 - IDDW - Public comment period ends April 22, 2015

Take Me Home, WV

- Nearly 100 members transitioned since April 5, 2013
- Expanding network of Transition Navigator provider agencies
- For more information, go to the program's website at <http://www.dhhr.wv.gov/bms/MFP/>

Facility Based and Residential Care

- New chapter for Children's Residential Care created in the BMS Provider Manual

BMS Quality Program

CMS Adult Quality Measures Grant

- Requires BMS to implement Quality Improvement Projects (QIPs)
 - Includes FFS and MCO members
 - Medical Record Requests delayed - pending CMS response
- QIPs
 - Improved Postpartum Care – onsite medical record reviews to be scheduled at pilot sites
 - CoventryCares – Cabell Huntington Hospital & 2 OB/Gyn providers
 - The Health Plan – Monongalia General Hospital & 3 OB/Gyn providers
 - UniCare – Thomas Memorial Hospital & 2 OB/Gyn providers
 - WV Family Health – pending (discussions underway)
 - Psychiatric Care – 6 pilot sites proposed

BMS Health Homes Program Update

WV Health Homes

- Launched July 1, 2014
- Medicaid members with bipolar disease who have or are at risk of having Hepatitis B or C
- Must be receiving services from a provider in
 - Cabell, Kanawha, Mercer, Putnam, Raleigh or Wayne counties
- Health Home Providers must offer a team approach to assist members with
 - Managing medical conditions and medications
 - Understanding medical tests and results
 - Remembering medical appointments
 - Other health care needs



BMS Health Homes Program Update

Currently, 934 members enrolled

Eight (8) BMS-approved Health Home Providers:

- Cabin Creek Health Systems
 - FMRS Health Systems
 - Marshall Health
 - Pretera Center for Mental Health
 - Process Strategies
 - Southern Highlands Community Health Center
 - WV Health Right
 - WomenCare, Inc. (FamilyCare)
-
- Additional Health Home Program information is available on the WV Bureau for Medical Services website: www.dhhr.wv.gov/bms/ or the APS Healthcare-WV website: www.apshealthcare.com/wv
 - Questions/concerns - contact APS Healthcare at 304-343-9663 or 1-800-461-0655.

Non-Emergency Transportation Update

Non-Emergency Medical Transportation (NEMT) Broker - MTM

NEMT statistics:

February 2015

Calls received – 41,328

Trips scheduled – 23,907

Trips denied – 1,558

YTD 2015

Calls received – 89,018

Trips scheduled - 50,557

Trips denied – 2,841

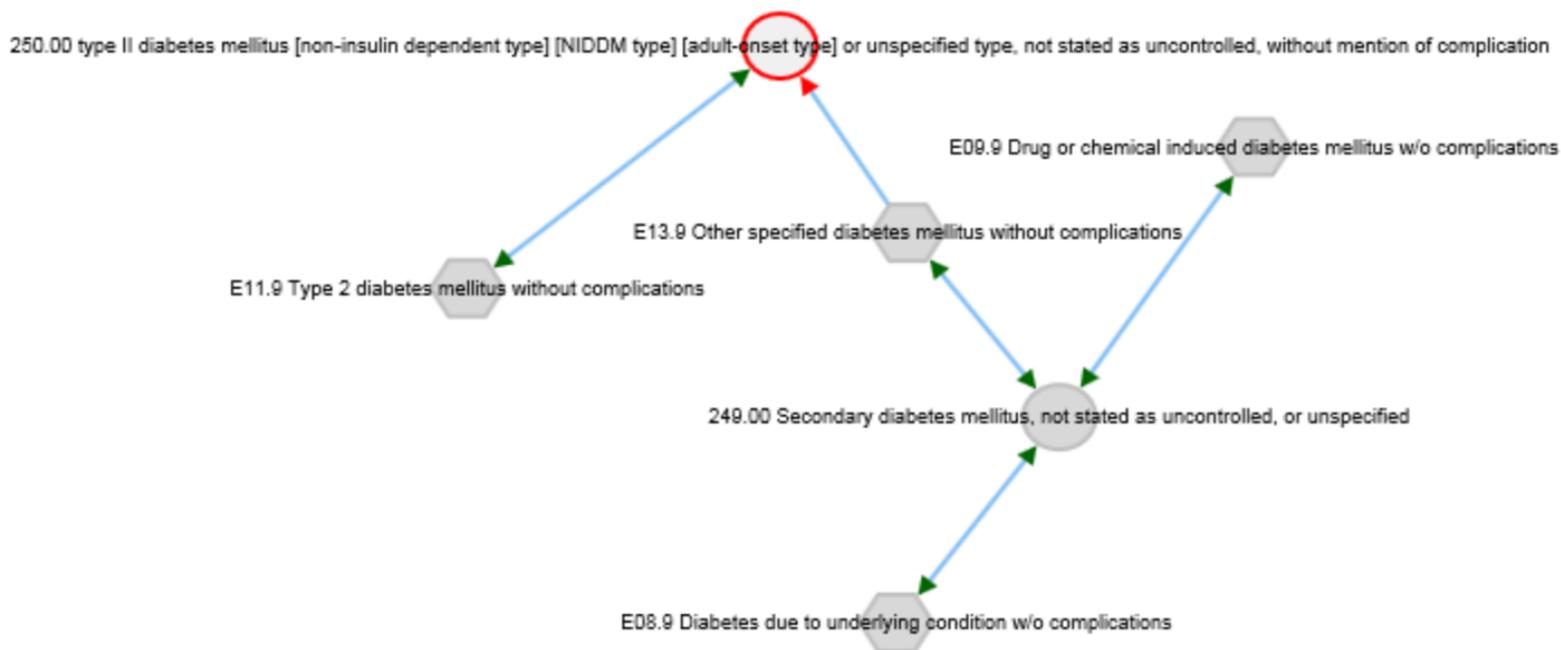
Compliance Date – October 1, 2015

- ICD- 10 resources:
 - Molina’s website under “ICD-10 Transition” link
 - Molina Biweekly Webinars
 - www.cms.gov/icd10
- Code mapping tool developed by University of Illinois and University of Arizona for public use
 - Diagnosis codes
 - ICD-9 to ICD-10
(<http://www.lussierlab.org/transition-to-ICD10CM>)
 - ICD-10 to ICD-9 (<http://lussierlab.org/transition-to-ICD9CM>)
 - Procedure Codes
 - ICD-9 to ICD-10 (<http://lussierlab.org/transition-to-ICD10PCS>)

ICD-9 to ICD-10 Code Mapping Tool

Legend

Node border color	BLACK	No association	Edge arrow color	DARK GREEN	Identity
	RED	Convolutd		BLACK	ICD-9-CM to ICD-10-CM
	TAN	Subclass to class	RED	ICD-10-CM to ICD-9-CM	
	LIGHT BLUE	Class to subclass	CIRCLE	ICD-9-CM	
	BLUE	Identity	HEXAGON	ICD-10-CM	
Node shape			CIRCLE	ICD-9-CM	
			HEXAGON	ICD-10-CM	



Boyd AD *et al.* "[The discriminatory cost of ICD-10-CM transition between clinical specialties: metrics, case study, and mitigating tools](#)". J Am Med Inform Assoc 013 epub 1 July 2013

ICD-9 to ICD-10 Code Mapping Tool

ICD-9-CM To ICD-10-CM Conversion (version 1.0)

Lussier Lab at University of Illinois at Chicago

DATE:3/20/2015 <http://www.lussierlab.net/transition-to-ICD10CM>

Legend: <=> ICD-9-CM to ICD-10-CM and ICD-10-CM to ICD-9-CM,
 "=>" ICD-9-CM to ICD-10-CM, but no ICD-10-CM to ICD-9-CM,
 "<=" ICD-10-CM to ICD-9-CM, but no ICD-9-CM to ICD-10-CM,
 "><" No mapping
 "R" Identity; "C" Class to subclass; "L" No association
 "S" Subclass to class; "H" Convoluted

Submitted ICD-9-CM	ICD9 TERM	Submitted values	ICD-9-CM	Relationship	ICD-10-CM	ICD10 TERM	Mapping Category
250.00	type II diabetes mellitus [non-insulin dependent type] [NIDDM type] [adult-onset type] or unspecified type, not stated as uncontrolled, without mention of complication		25000	<=>	E119	Type 2 diabetes mellitus without complications	H
			25000	<==	E139	Other specified diabetes mellitus without complications	
			24900	<=>			
			24900	<=>	E089	Diabetes due to underlying condition w/o complications	
			24900	<=>	E099	Drug or chemical induced diabetes mellitus w/o complications	

Boyd AD *et al.* "[The discriminatory cost of ICD-10-CM transition between clinical specialties: metrics, case study, and mitigating tools](#)". J Am Med Inform Assoc 013 epub 1 July 2013

- BMS Policy Remediation to be completed by May 31, 2015
 - Policies to be released using current process
 - Draft policy posted to BMS website
 - 30-day Public Comment Period
- External testing to begin June 2015
- Provider Readiness Surveys will continue
- For more information:
 - Molina's website under "ICD-10 Transition" link
 - Molina Biweekly Webinars
 - www.cms.gov/icd10

ICD-10 Policy Remediation

New Format for BMS Policy

- **NOTE:** This is a sample of the new policy format that BMS will be using when the existing policy is remediated for ICD-10. This is not an actual policy.



519.6 CARDIAC REHABILITATION

POLICY METADATA

Policy ID = 519.6	Initial Approval Date = 4/1/2013
Policy Author = Professional Service:	Initial Effective Date = 4/1/2013
Policy Status = Pending	Last Revised Date = 10/14/2014
Creation Date = 4/1/2013	Revision Approval Date = TBD
	Next Review Date = Date.

BACKGROUND

Cardiac rehabilitation is a comprehensive outpatient program of medical evaluation, prescribed exercise, cardiac risk factor modification, and education and counseling that is designed to restore members with heart disease to active, productive lives. The central component of cardiac rehabilitation is a prescribed regimen of physical exercises intended to improve functional work capacity and to improve the member's well-being.

POLICY

Cardiac rehabilitation programs are regulated exercise programs which are effective in the physiological and psychological rehabilitation of many members with cardiac conditions. The program consists of a series of supervised exercise sessions with continuous electrocardiograph monitoring. Cardiac rehabilitation can be performed in a specialized, freestanding physician-directed clinic or in an outpatient hospital department. Members who use tobacco must be referred to the tobacco cessation program. Please see [519.21, Tobacco Cessation Services](#).

The goals of cardiac rehabilitation are to:

- Increase exercise tolerance
- Reduce symptoms of chest pain and shortness of breath
- Improve blood cholesterol levels
- Improve psychosocial well-being
- Reduce mortality

These services are considered medically necessary for selected members when they are individually prescribed by a physician within a 24 week (6 month) window after any of the following:

- Acute myocardial infarction
- Other acute and subacute forms of ischemic heart disease
- Old myocardial infarction
- Angina pectoris
- Other forms of chronic ischemic heart disease
- Other diseases of endocardium (e.g. valve disorders, mitral, aortic, tricuspid, pulmonary, endocarditis)



519.6 CARDIAC REHABILITATION

Cardiac dysrhythmias

- Heart Failure
- Cardiomegaly
- Functional disturbances following cardiac surgery
- Complications of transplanted organ, heart
- Organ or tissue replaced by other means; heart
- Organ or tissue replaced by other means; heart valve
- Other post procedural states; unspecified cardiac device
- Other post procedural states; automatic implantable cardiac defibrillator
- Other post procedural states; percutaneous transluminal coronary angioplasty status
- Personal history of other cardiorespiratory problems; exercise intolerance with pain: at rest, with less than ordinary activity, with ordinary activity.

519.6.1 FREQUENCY AND DURATION

The medically necessary frequency and duration of cardiac rehabilitation is determined by the member's level of cardiac risk stratification. High risk members who have any one of the following are eligible for cardiac rehabilitation:

- Exercise test limited to less than or equal to 5 metabolic equivalents (METs)
- Marked exercise-induced ischemia, as indicated by either angina pain or 2 mm or more ST depression by ECG
- Severely depressed left ventricular function (ejection fraction less than 30%)
- Resting complex ventricular arrhythmia
- Ventricular arrhythmia appearing or increasing with exercise or occurring in the recovery phase of stress testing
- Decrease in systolic blood pressure of 15 mm Hg or more with exercise
- Recent myocardial infarction (less than 6 months) which was complicated by serious ventricular arrhythmia, cardiogenic shock or congestive heart failure
- Survivor of sudden cardiac arrest.

519.6.2 PROGRAM DESCRIPTION FOR HIGH RISK MEMBERS

The cardiac rehabilitation program is composed of:

- 36 sessions (e.g., 3x/week for 12 weeks) of supervised exercise. For members of the expansion population under the alternative benefits plan service limits include both rehabilitative and habitative services. Please see [Chapter 400, Member Eligibility](#) for additional information.
- Educational program (a/risk factor/stress reduction
- Creation of an individual outpatient exercise program that can be self-monitored and maintained
- If no clinically significant arrhythmia is documented during the first three weeks of the program, the provider may have the member complete the remaining portion without telemetry monitoring.
- Following the initial evaluation, services provided in conjunction with a cardiac rehabilitation program may be considered reasonable for up to 36 sessions, usually 3 sessions per week, for a 12 week period.

Provider Revalidation Phases

Phase 1: Direct Providers

Phase 2: Directs classified as Groups

Phase 3: Groups of 50 or less providers

Phase 4: Groups of 51 or more providers

Phase 5: Remaining Directs & Groups including but not limited to Audiologist, Chiropractor, Advanced Practice Nurse (CNM, CNS, CRNA, NP) and Optometrist

Phase 6: Ambulatory Surgery Center, Audiology, Case Management Agency, Home Health, Homemaker Agency, Independent Lab, Independent Radiologists, Occupational Therapist, Physical Therapist, Speech Therapist, Renal Center

Phase 7: Federally Qualified Health Centers, Rural Health Clinics

Phase 8: Birthing Center, Dentists, Domestic Violence Center, DMEPOS, Mental Health Clinic, Mental Health Clinic BHHF, Mental Health Rehabilitation, Mental Hospital < 21, Personal Care Provider, Prosthetic Supplier, Psychologists

Phase 9: Pharmacy, LTC, Hospice, Nursing Care Agency, Respite and Habilitation

Phase 10: Transportation, Mental Hospitals, Inpatient Hospitals, Podiatrist, Transition Navigator

Phase 11: Atypical Providers (Health Departments, County Boards of Education, Public Health Agencies)

Revised Revalidation Payhold & Termination Dates

■ **April 2015**

- Medicaid participation will be terminated for all Phase 1 through 4 providers who are currently on Payhold and have not submitted a complete application for revalidation
- All providers in Phases 5 through 8 who have not submitted a complete application for revalidation will be placed on Payhold
 - Provider names, NPI and address will be posted on Molina and BMS website for 2 weeks prior to Payhold

■ **June 30, 2015**

- All Phase 1 through 10 providers must have submitted complete application revalidation or be placed on Payhold

■ **October 1, 2015**

- Medicaid participation will be terminated for all Phase 1 through 10 providers who have not submitted complete application for revalidation

- Quarterly Updates
- Reprocessing of Claims
- Upcoming Change - Date of Service (DOS) MUEs
 - Announced late 2014; target date pending
 - Currently in Medicare NCCI edits
 - A DOS MUE adds together the submitted units of service for a given HCPCS/CPT code on all lines of the presenting claim and all paid claim lines on claims in history billed by the same provider for the same member for the same DOS.
 - CMS current plan is to phase in DOS MUEs over several quarters
- NCCI Medicaid website: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html>

Claim Edits

■ Provider Enrollment and Information Edits

Claim Edit Name & Disposition	Edit Description	Target Date for Edit Implementation
Ordering/Referring/Prescribing Provider Information - Deny	Current edit disposition of "Warn" (implemented in June 2014) will be changed to "Deny" when ordering/referring/prescribing provider information is not on claim.	May 31, 2015
Ordering/Referring Prescribing Enrollment - Warn	Implement edit disposition of "Warn" when ordering/referring provider not enrolled or when ordering/referring provider NPI is organizational NPI.	July 1, 2015
Ordering/Referring/Prescribing Enrollment - Deny	Change edit disposition to "Deny" when ordering/referring provider not enrolled or when ordering/referring provider NPI is organizational NPI.	Last quarter 2015 following completion of provider revalidation.
Attending Provider Information - Warn	Implement edit disposition of "Warn" when required attending provider information is not present on claims submitted via Web Portal (Direct Data Entry) and paper.	May 31, 2015
Attending Provider Information - Deny	Change edit disposition to "Deny" when required attending provider information is not present on claims submitted via Web Portal (Direct Data Entry) and paper.	July 1, 2015
Attending Provider Enrollment - Warn	Implement edit to "Warn" when attending provider is not enrolled or when attending provider NPI is organizational NPI.	July 1, 2015
Attending Provider Enrollment - Deny	Change edit disposition to "Deny" when attending provider is not enrolled or when attending provider NPI is organizational NPI.	Last quarter 2015 following completion of provider revalidation.

Ordering/Referring/Prescribing (ORP) Providers

- Do not bill WV Medicaid directly
- If ORP not enrolled in WV Medicaid, then servicing provider claim will not be paid
 - Example:
 - ER Patient receives order for follow-up chest x-ray from ORP Provider, such as Physician's Assistant
 - Patient returns to hospital for follow-up chest x-ray
 - Hospital claim submitted with name of ORP as provider who ordered chest x-ray
 - If ORP Provider is not enrolled in WV Medicaid, hospital claim is denied
- Watch for updates on website, provider newsletter, remittance advice, banner page

BMS Program Integrity (PI)

- Medicaid MCO data now available for PI reviews
- Current reviews:
 - Electronic Health Record (EHR) Audit
 - Final reports to be released mid to late summer 2015
 - Disallowances will be applied
 - Enhanced Payments to Primary Care
 - 2013 Audit of Specialty Compliance and 60% Requirement underway
 - 2014 Audit to begin mid-summer
 - Medicaid Integrity Group (MIG)
 - Vendor – Health Integrity
 - Hospice audit - final reports to be released late summer
 - Lab audits – claim data analysis underway
 - Medicare-Medicaid (Medi-Medi) Data Match
 - Effective April 1, 2015
 - Audits in collaboration with BMS
- New PERM Cycle – Medical Record Requests in Spring 2016 for Dates of Service beginning 10/1/15 to 09/30/16

WV Clearance for Access: Registry & Employment Screening (WV CARES)

- Provision under the Affordable Care Act of 2010
- All direct access employees are required to undergo a comprehensive background check
 - Required Registry Checks
 - Fingerprint-Based Criminal Background Check
- Legislation passed during the 2015 Legislative Session
 - Authorizes the WV CARES staff to receive criminal background check results
 - WV CARES staff will perform fitness determination for prospective new long-term care employees

WV CARES System

- Web-based system to be implemented in 2 phases
- Phase 1 – Allows employers to conduct required registry checks
 - Current employee upload function
 - Conducts automated monthly required registry rechecks
 - Initial provider pilot testing – January 2015
 - Phase-in process for all long-term care providers – approximately May 2015
- Phase 2 – Fitness determination based on fingerprint-based background check

ANNUAL MEDICAID CARDS

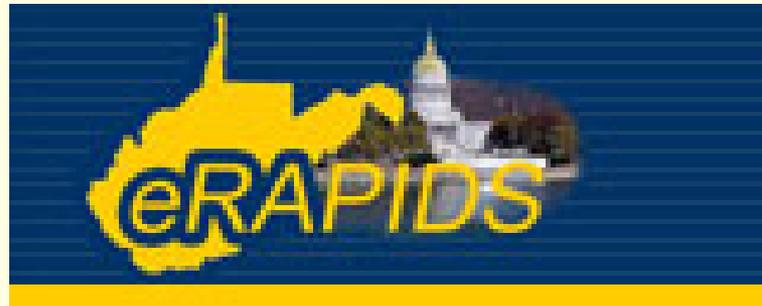
Kristen Childress

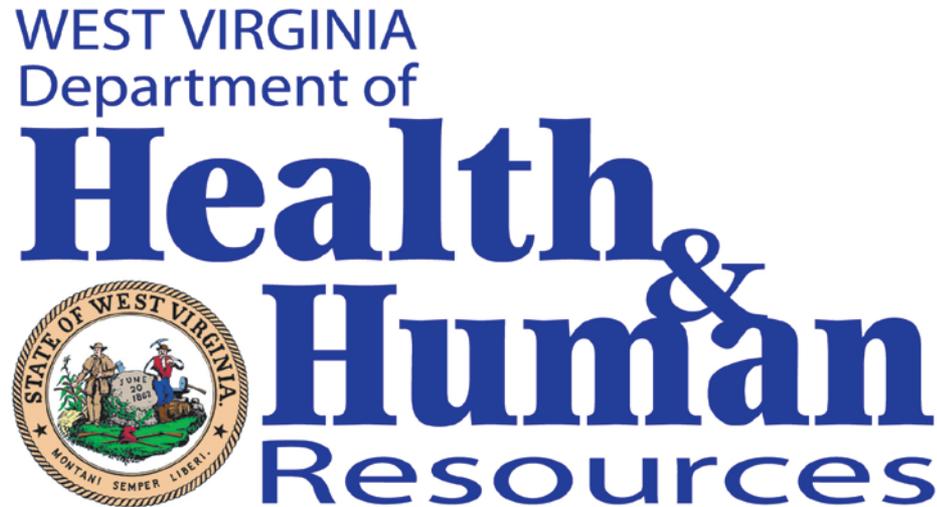
RAPIDS Project Outreach and Communications Coordinator
Office of Management Information Services

West Virginia
Department of Health & Human Resources (DHHR)
April 13, 2015



RAPIDS Project





MISSION STATEMENT

The West Virginia Department of Health and Human Resources' mission is to promote and provide appropriate health and human services for the people of West Virginia, in order to improve their quality of life.

Annual Medicaid Card

UNAUTHORIZED USE IS
A FRAUDULENT PRACTICE

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
MEDICAL I.D. CARD

SEE NOTICE ON BACK
KEEP THIS CARD

SMITH, JENNIFER
1012 KANAWHA BLVD
CHARLESTON, WV 25312

CASE NO. **3333333333**
PROV. NO.

FS
CK

FROM
TO

VALID ONLY

MAID NO.	PLAN	CLIENT NAME	BIRTH DATE	PAAS/LOCKIN/HMO PROV	PROVIDER PHONE	TPL PROVIDER	POLICY NO.
0022222222		SMITH, JENNIFER	09/12/1997				
0033333333		SMITH, CALVIN	03/17/1999				

Provider: Login to provider portal at www.wvmmis.com or call AVRS 888-483-0793 to verify HMO and Benefits Package.

YOU MUST SHOW THIS CARD TO GET MEDICAL SERVICES

REMOVE DOCUMENT ALONG THIS PERFORATION

WARNING - THE USE OF THE MEDICAL CARD HEREIN ENCLOSED BY ANY PERSON OTHER THAN THE INDIVIDUALS DESIGNATED ON THE CARD WILL CONSTITUTE AN OFFENSE, WHICH WILL BE PROSECUTED TO THE FULLEST EXTENT OF THE LAW.

NOTICE

The April Medicaid Card will be the last monthly card you will receive in 2015. You will no longer be receiving a Medicaid Card each month, but instead, one card that you will use throughout the year. Please be sure to keep it in a safe place so you will have it when you need it. You will receive more information in the mail regarding this change.

Who Should the Member Contact?

If members need a replacement card or need to report a change in their household they have two options below:

- **Contact a case worker at local Department of Health and Human Resources (DHHR) office, or**
- **Contact the DHHR Customer Service Center at 1-877-716-1212.**

Who Should the Provider Contact?

If you have a patient who comes to your office and does not have his/her Medicaid card and you have a question about whether they are still eligible for coverage, you can check their eligibility status by:

- Going to www.wvmmis.com, Molina's Provider Portal, or
- Calling Molina Provider Services at 1-888-483-0793.

**THIS CHANGE IS EXPECTED TO SAVE
WEST VIRGINIA
\$2.5 MILLION A YEAR**



QUESTIONS OR FEEDBACK
ON ANNUAL MEDICAID CARD?

CONTACT

KRISTEN CHILDRESS
RAPIDS PROJECT OUTREACH AND COMMUNICATIONS
COORDINATOR

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