



ProviderNews

Timely News & Information Of Interest To Healthcare Providers

PPB Changes for Plan Year 2013

Plan Year 2013, which began on July 1, 2012, brings a number of changes to PEIA's Preferred Provider Benefit (PPB) Plans A, B and C. The agency also introduced a new plan, Plan D, also known as the West Virginia-Only Plan.

Members enrolled in Plan D must be West Virginia residents, and with few exceptions, all care must be provided in West Virginia. More information about Plan D is available at www.wvpeia.com. Go to "Our Services," "Preferred Provider (PPB) Plans" and "What is Preferred Provider (PPB) Plan D."

The following are Plan Year 2013 changes and how they affect PPB Plans A, B, C and D:

PPB CHANGES - *Non-Preferred Drug Costs Jump*

PEIA's PPB plans provide drug coverage using a three-tiered formulary. Member copayments for drugs depend on the type and tier of drug they take. Generic drugs make up Tier 1. Tier 2 is preferred brand name drugs: drugs that appear on PEIA's Preferred Drug List. Tier 3 is comprised of all brand name drugs that are not on the Preferred Drug List.

Beginning July 1, PEIA has made a substantial increase in the patient's cost for Tier 3 drugs. The non-preferred (Tier 3) drug copayment increases from \$50 to 75% coinsurance for all PPB Plans and the Special Medicare Plan for Plan Year 2013.

The plan will pay 25% of the drug cost and member pays 75%. The 75% coinsurance will be applied to the member's annual prescription drug out-of-pocket maximum and deductible.

Along with the cost-sharing change, PEIA has eliminated the maintenance medication discount for Tier 3 drugs. Members will be able to purchase a 3-month supply of non-preferred drugs on the Maintenance Medication list, but they will not receive any cost-sharing advantage for doing so.

PPB CHANGES - *Affordable Care Act Requires Preventive Services*

All PPB plans offered this year are subject to the provisions of the Patient Protection and Affordable Care Act, which became law in 2010 and was recently upheld by the U.S. Supreme Court. Therefore, there are a number of new preventive benefits available to patients without deductible, copayment or coinsurance, effective July 1, 2012.

For a list of preventive services now covered, go to "Forms & Downloads," "Providers" and "Other Documents" on PEIA's Web site, www.wvpeia.com. Look for the document called

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online anytime

www.wvpeia.com

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“Preventive Care Covered by Affordable Care Act.”

The plans will also include an enhanced external appeal procedure. Details of the new appeals procedure will be provided in the Plan Year 2013 Summary Plan Description. Go to “Forms & Downloads,” “Providers” and “Summary Plan Descriptions” on PEIA’s Web site, www.wvpeia.com.

PPB CHANGES - *New Express Scripts Drug Formulary*

Express Scripts released an updated prescription drug formulary for patients covered by all PPB Plans, effective July 1, 2012.

The formulary, or High Performance Preferred Drug List, is on PEIA’s Web site, www.wvpeia.com, under “Forms & Downloads,” “Providers” and “Prescription Drug Benefits.” The formulary is provided in alphabetical form and by therapeutic class.

Express Scripts notified you of your specific patients who are seeing drugs moving from Tier 2 (preferred) to Tier 3 (non-preferred). The letter included suggested formulary or generic alternatives which would save your patients money.

Beginning on July 1, 2012, Tier 3 drugs will carry a 75% coinsurance. (See Non-Preferred Drugs story on page one.)

If you have questions about the changes, wish to request a copy of the abbreviated formulary or need more information, call Express Scripts at 1-877-256-4680.

PPB CHANGES - *Specialty Injectable Drugs Require Prior Authorization*

PEIA provides coverage for specialty drugs, including injectables. Some drugs are covered under the medical benefit plan, and some under the prescription drug program.

Beginning July 1, PEIA will require prior authorization of all new prescriptions for specialty drugs from HealthSmart Benefit Solutions for patients covered by any PPB Plan.

HealthSmart will review new requests for medical necessity. If approved, HealthSmart will coordinate the purchase through an approved source and let you know where to call in the prescription. HealthSmart also will let your patient know how he or she will receive the

drug. In addition, any educational needs will be addressed at that time.

If denied, HealthSmart will contact you for additional information to ensure the correct decision has been made about medical necessity.

To request approval for a medication or for more information about the program, contact HealthSmart at 1-888-440-7342 (choose option 1 followed by option 7).

PPB CHANGES - *Outpatient Therapy Changes*

PEIA has changed how outpatient therapy services are administered under PPB Plans A, B and D. Outpatient therapy services under Plan C were not changed for the upcoming plan year.

PEIA’s outpatient therapy benefit combines all outpatient therapy services: physical therapy, occupational therapy, speech therapy, massage therapy and chiropractic services into one benefit with a 20-visit-per-plan-year limit. Therapy beyond the 20th visit requires case management from ActiveHealth.

**New Copayments**

Effective July 1, 2012, patients will pay a \$10-per-visit copayment for medically necessary outpatient physical, occupational, speech and massage

therapy and chiropractic services for the first 20 visits in a plan year. PEIA no longer covers acupuncture, and massage therapy has new requirements. (See Acupuncture and Massage Therapy story on page three.)

The \$10 copayment is in addition to deductible and the 20 percent coinsurance.

Case Management

If more than 20 outpatient therapy visits are medically necessary, the additional therapy must be approved and case managed by ActiveHealth. Visits beyond the first 20 also require a \$25 copayment, plus deductible and coinsurance.

To request approval of therapy beyond the 20-visit limit, contact ActiveHealth at 1-304-353-7820 or 1-888-440-7342 (toll-free).

PPB CHANGES - Acupuncture, Massage Therapy Changes

PPB Plans will no longer cover acupuncture services. In addition, massage therapy providers must carry malpractice insurance and follow standard treatment guidelines.

Previously covered as an outpatient therapy benefit, acupuncture services rendered on or after July 1, 2012, will not be paid.

Massage therapy remains covered, but massage therapists now must carry \$2 million in malpractice insurance and follow treatment guidelines of the American Massage Therapy Association. The following plan year, starting July 1, 2013, massage therapists must have national certification to be eligible for reimbursement by PEIA.

Patients receiving massage therapy will now be required to pay a \$10 copayment in addition the deductible and the 20 percent coinsurance. (See Outpatient Therapy Changes story on page two.)

For more information, go to “Forms & Downloads,” “Provider” and “PEIA Policies” on the PEIA Web site, www.wvpeia.com.

PPB CHANGES - Two Additional Outpatient Services Require Precertification

PEIA added two outpatient services to those requiring precertification under all PPB Plans.

Dialysis services will require precertification to ensure patients are referred to an approved facility. Hyperbaric oxygen therapy will require precertification to determine medical necessity. (See list of all inpatient and outpatient services requiring precertification on page five.)

To request precertification for a service, contact ActiveHealth at 1-304-353-7820 or 1-888-440-7342 (toll-free).

PPB CHANGES - Autism Coverage Begins

PPB Plans will begin covering some diagnostic and treatment services for dependent children with autism spectrum disorders (ASD).

Applied behavior analysis (ABA) services will be limited to \$30,000 per child, per year for three consecutive years from the date treatment starts for a child with a diagnosis of ASD prior to the child's eighth birthday. After the third consecutive year of treatment is concluded, ABA coverage shall not exceed \$2,000 per month until the child reaches age

eighteen, or is no longer eligible for PEIA coverage, and as long as treatment is medically necessary.

Coverage

Coverage includes the following diagnostic assessments of ASD for children 18 months until their 8th birthday, including diagnostic tests to rule out underlying causes, as appropriate:

- Medically necessary evaluations/assessments or tests performed by a provider practicing within the scope of his/her license
- Developmental screening with an instrument with predictive validity for ASD, such as M-CHAT or the ASQ-SE
- Evaluation by speech-language pathologist
- Formal audiological hearing evaluation by an audiologist
- Medical evaluation (complete medical history and physical examination)
- Parent and/or child interview (including siblings of children with ASD)
- Behavioral assessment by a behavioral health licensed practitioner, psychiatric assessment for differential diagnosis, co-morbidity, or problem behaviors

Treatment

- Prescription Medications (those FDA-approved specifically for treatment of autism)
- Psychiatrist evaluations – direct or consultative
- Psychologist evaluations – direct or consultative
- Interventions and therapeutic services:
- Applied Behavioral Analysis (ABA)
- Discrete Trial Training (DTT)
- Speech/language therapy
- Occupational therapy
- Physical therapy
- Psychological or cognitive assessment by a licensed psychologist is covered if medically necessary for clarifying the diagnosis

For more detailed information about coverage for autism, review the policy on PEIA's Web site, www.wvpeia.com, under “Forms & Downloads” and “Providers” and “PEIA Policies.”

Humana Takes Over Medicare Advantage Drug Program

Effective on July 1, 2012, prescription drug benefits for retirees covered by the Humana Medicare Advantage Plan will be transferred from Express Scripts to Humana.

With the Humana plan, there are drugs with special requirements, and these are noted in the formulary that can be accessed online at <http://apps.humana.com/marketing/documents.asp?file=1858298>. Please review this information and the formulary, so PEIA retirees can have their prescriptions filled without delay.

Prior Authorization

Prior authorization means the member needs approval from Humana before they fill a prescription. The reason for this requirement can vary depending on the drug, but without prior approval, Humana may not cover the prescription cost. If you prescribe a drug on the Prior Authorization list, be sure you have obtained approval **before** the retiree has the prescription filled.

The Prior Authorization turnaround time mandated by CMS is 72 hours. However, physicians can request an expedited review (24 hours), if it will harm the patient to wait 72 hours.

Step Therapy

Step Therapy drugs **can be prescribed only after a member has tried alternatives for their condition**. The reason a drug is on the Step Therapy list can vary, but the member must have fulfilled any requirements before a Step Therapy prescription can be filled.

Quantity limits

Quantity limits mean a member can only get a certain quantity of a medication at one time. It's also called the "maximum allowable quantity."

On the effective date with Humana, if a member fills or refills a prescription for one of the drugs with quantity limits, they can fill the prescription *up to* the maximum allowable quantity. However, if the member requires more than the maximum allowable quantity, providers can call the Humana Clinical Pharmacy Review to discuss coverage options.

To obtain approval:

Go online to Humana.com and select "For Providers" under "Humana Web Sites." Next, go to "Pharmacy Tools" under "Providers." Scroll down and select "Prior Authorization." Scroll down to find the fax forms. Fax the request to 1-877-486-2621, using the Humana fax forms. (Fax forms are available online at Humana.com.)

Call Humana Clinical Pharmacy Review (1-800-555-2546) with questions about drugs with prior authorizations, step therapy, and/or quantity limits. Representatives are available Monday through Friday, 8 a.m. to 6 p.m.

Access the Humana PEIA formulary online at: <http://apps.humana.com/marketing/documents.asp?file=1858298>.

Sleep Management Update

Sleep Management Solutions, PEIA's sleep benefits management services vendor, has updated the PEIA program criteria for the use of Home Sleep Testing (HST) services.

Effective April 1, 2012, a patient's BMI is being removed as an exclusionary component for the approval of HST services. Patients will no longer



be excluded from receiving HSTs due to body mass index, since HSTs have proven to be effective with all patients regardless of the BMI. Additionally, the age range has been expanded to include 16 years of age and older for the appropriateness of receiving an HST.

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Services Requiring Precertification

Inpatient Admissions Requiring Precertification

- Hysterectomy
- Laminectomy
- Laminectomy with spinal fusion surgery
- Discectomy with spinal fusion surgery
- Spinal fusion surgery
- Artificial intervertebral disc surgery
- Insertion of implantable devices including, but not limited to; implantable pumps, spinal cord stimulators, neuromuscular stimulators and bone growth stimulators
- Cochlear implants
- Uvulopalatopharyngoplasty
- Elective and cosmetic surgeries including but not limited to abdominoplasty, blepharoplasty, breast reduction, breast reconstruction, panniculectomy, penile implants/vascular procedures, otoplasty, rhinoplasty, scar revision, testicular prosthesis, and surgery for varicose veins
- Bariatric surgery (gastric bypass, Lap-band, sleeve gastrectomy)
- Transplants and transplant evaluations (including but not limited to: kidney, liver, heart, lung and pancreas, small bowel, and bone marrow replacement or stem cell transfer after high dose chemotherapy)
- Mental health and substance abuse treatment
- All admissions to out-of-state hospitals/facilities

Outpatient Services Requiring Precertification

- Medical Case Management Services in the home:
 1. arrange home care to prevent hospitalization
 2. arrange services in the home to facilitate early hospital discharge
 3. obtain discounts for special medical equipment
 4. locate appropriate services to meet the patient's health care needs
 5. and for catastrophic cases, when medically proven as a part of a comprehensive plan of care, allow additional visits for outpatient mental health or Outpatient Therapy Services
 6. under very limited circumstances, allow additional visits for short-term outpatient physical therapy services for treatment of a separate condition which is also a new incident or illness - not an exacerbation of a chronic illness
- Partial/day mental health and substance abuse treatment programs
- Durable medical equipment purchases and/or rentals of \$1,000 or more

Surgeries:

1. hysterectomy
 2. implantable devices including, but not limited to: implantable pumps, spinal cord stimulators, neuromuscular
 3. stimulators, and bone growth stimulators
 4. uvulopalatopharyngoplasty
 5. elective and cosmetic surgeries including but not limited to abdominoplasty, blepharoplasty, breast reduction, breast reconstruction, panniculectomy, penile implants/vascular procedures, otoplasty, rhinoplasty, scar revision, testicular prosthesis, and surgery for varicose veins
 6. bariatric surgery (Lap band)
 7. transplants
 8. discectomy with spinal fusion surgery
 9. laminectomy
 10. laminectomy with spinal fusion surgery
 11. spinal fusion surgery
 12. artificial disc surgery
- Sleep studies, services and equipment
 - Continuous glucose monitors
 - Any potentially experimental/investigational procedure, medical device, or treatment
 - CT scan of sinuses or brain
 - CTA (CT angiography)
 - MRI scan of knee and spine (includes cervical, thoracic, and lumbar)
 - SPECT (single photon emission computed tomography) of brain and lung
 - IMRT (intensity modulated radiation therapy)
 - Elective (non-emergent) facility to facility air ambulance transportation
 - Limited Molecular Diagnostic/Genetic Testing to include the following 5 tests: Hereditary Non-polyposis
 - Colorectal Cancer (HNPCC) testing, BRCA gene testing, Oncotype DX, Familial Adenomatous Polyposis (FAP) testing, Catecholaminergic Polymorphic Ventricular Tachycardia (FPVT) testing
 - Cochlear implants
 - Dialysis
 - Hyperbaric oxygen therapy

To request precertification for a service, contact Active-Health at 1-304-353-7820 or 1-888-440-7342 (toll-free).

Tobacco Cessation Benefits

Good things happen when tobacco users give up the habit, and PEIA's tobacco cessation benefits can help.

All PPB plans provide tobacco cessation benefits focused on the provider-patient relationship. To that end, we provide reimbursement for your tobacco-cessation counseling services as follows:

The provider may bill for an office visit when documented.

In addition to the office visit, the physician may also bill for counseling services as follows:

CPT Code	PEIA Allowance	Description
99406	\$13.57	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
99407	\$27.49	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes

The above-listed CPT codes are covered at 100 percent of the PEIA allowance.

There is a maximum of two counseling visits per 12-month period, per patient.

This benefit is limited to three attempts in a member's lifetime.

Nicotine patches are covered at no cost to the patient (deductible and copayments are waived) when prescribed by a physician and purchased at a network pharmacy.

Other prescription and over-the-counter cessation products are covered with the applicable generic, preferred or non-preferred copayments.

SLEEP MANAGEMENT continued from page four

These criteria changes will allow Sleep Management Solutions to continue to provide quality care for patients who may suffer from obstructive sleep apnea.

For more information, call Sleep Management Solutions at 1-888-497-5337 or visit their website at www.wvpeiasleep.com for the complete updated criteria.

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